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THE TRAGEDY OF ELDER ABUSE: THE PROBLEM AND THE RESPONSE

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HEARING

BEFORE THE

SUBCOMMITTEE ON
HOUSING AND CONSUMER INTERESTS

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

JULY 1, 1986, NASHVILLE, TN

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THE TRAGEDY OF ELDER ABUSE: THE PROBLEM AND THE RESPONSE

TUESDAY, JULY 1, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HOUSING AND CONSUMER INTERESTS,
Nashville, TN.

The subcommittee met, pursuant to notice, at 9:10 a.m., in room 353, Tennessee State University, Downtown Campus, 10th and Charlotte Streets, Nashville, TN, Hon. William Hill Boner (acting chairman of the subcommittee) presiding.

Members present: Representatives Boner and Gordon.

Staff present: Susan Able, research assistant; Norma Blankenship Clements, legislative assistant; David Flanders, associate staff; Betty Murray, district office manager; Billy Fields, press secretary; and Patricia Tate, staff assistant.

OPENING STATEMENT OF REPRESENTATIVE WILLIAM HILL BONER

Mr. BONER. I would like to call to order now the public hearing on the Select Committee on Aging. I want to thank all of you for being here, and those who will be participating in the meeting.

I want to thank my colleague, Bart Gordon, for being here with me this morning, and especially to thank the fine panel, who have volunteered so much time and effort, and the others who have come here today.

The hearing we are holding today is not on a pleasant subject. The majority of us look forward to our elder years with contentment—a time for rest and relaxation. However, the average citizen is not aware that a great many elderly people are living out those years in fear, and in some cases, shame.

The Select Committee on Aging has studied this problem and found that, tragically, each year over 1 million older Americans are physically, financially, and emotionally abused by their relatives or loved ones. These abuses range from actual physical assaults to thefts of monthly benefit checks. Unfortunately, due to fear or dependence on their abusers, only about one out of six of these abuses is likely to be reported to the authorities.

What we would like to achieve here today is an awareness of how prevalent this problem is, how the community and the State are dealing with the problem, and what response is needed on the Federal level.

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We look forward to hearing the testimony that will be given today. We are thankful that all of you are here today to help us. Let us hope that today's hearing will help stimulate interest needed to help those tragic people who are being abused.

At this time I would like to call on my colleague, Congressman Bart Gordon, for his opening remarks.

STATEMENT OF REPRESENTATIVE BART GORDON

Mr. GORDON. Thank you very much for having me here today. I compliment you on convening this hearing on the subject of elderly abuse, and I, too, hope this hearing will be successful in creating awareness of the prevalence of this problem and give us, as Members of Congress, some insight into how we can address the problem.

On a more personal basis, let me say, 2 years ago before I was elected to Congress, I had no awareness of this type of problem, and over the last couple of years, I have had almost 200 open meetings around my district, and many of those attending are elderly, and this subject has come up more than once.

It is shocking, but it is something that we cannot just turn our head and hope will go away.

We have to realize it is out there, and we have to do something about it.

I compliment you on getting us together today.

Mr. BONER. There are several pieces of legislation that are presently introduced in the Congress, and some are being currently formulated.

One of the things we will do through this public hearing, all the statements made, all the testimonies given, both oral and submitted in writing, will be submitted and made a part of the record and presented to our Committee on Aging.

We are optimistic as a result of this, and other meetings like this, all over the United States by other members of the Select Committee on Aging, we are going to increase the awareness of the abuse on elderly, and try to look to the Federal level to see what can be done to assist.

Before we hear testimony from our panel, I would like to introduce a friend and special guest, Tom Ervin, executive vice president and general manager of WTVF, the channel 5 television station here in Nashville. Mr. Ervin is the recipient of several awards for his leadership in this community and in broadcasting, and recently produced an award-winning news series on aging. I have asked him here today to share that experience with us. Tom, welcome. Bart and I very much appreciate you being available for this hearing.

Mr. GORDON. Let me say I had the good fortune to participate in the program of Aging: A Family Affair, and I think it was a great experience and very beneficial to middle Tennessee, for many reasons.

First of all, I was there helping to man the phones, as some of the folks were here, and there were calls after calls, hundreds of people called on into the night wanting to know, how could they get help on this or that problem, and the amazing thing was, at

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least two-thirds of the calls I received were from people my age, and they were asking about how could they help their parents and grandparents.

I think a great deal was accomplished that night, in getting the problem connected with the solutions. That was the short term.

I know that a toll-free number was set up that allowed individuals to call, and find out how they could reach assistance, and it helped to raise the awareness all over Tennessee of this problem. I want to thank channel 5, and particularly Tom, because I know he has a personal interest in this, and if it wasn't for his commitment to see that the hours and the resources were committed to this program, it would never have been done.

I have been trying to work out where Tom could come to Washington, testify before the Select Committee on Aging there, put this program together as a model, on a national basis, so that other stations across the country don't have to reinvent the wheel, see how it was done here, and use as a model in their own area.

It would be a major benefit to the country and hopefully one day we will have a national toll-free number to help victims, and help them get put in contact with all the resources.

Your program helped put the program, or the people's problem in touch with the resources. I thank you for that.

STATEMENT OF TOM ERVIN, EXECUTIVE VICE PRESIDENT AND GENERAL MANAGER, WTVF-TV, NASHVILLE, TN

Mr. ERVIN. I thank both of you very much.

I would like to acknowledge, too, the fact that those of us in middle Tennessee are very proud of the fact that we have two Congressmen from our immediate area serving on the House Select Committee on Aging, because it is such an important issue for all of us. What occurred last winter here in Nashville demonstrates one way a community with media support can streamline information and referral systems to the growing numbers of our aging neighbors.

These experiences by those aging persons and their families form what I call "emotional abuse" people, we will be looking at physical and emotional and financial abuse.

My remarks are along the lines of that emotional abuse.

Several years ago, my mother needed a lot of help, and in my willingness to help her, I first discovered that it is difficult, No. 1, to locate the agency that will provide the service. They are there because many people know that there are many good service-rendering agencies in our area, and there are thousands of families and individuals in need of that service.

Oftentimes it is difficult as you suggested a moment ago, to have those two bodies getting together.

There are many professionals and volunteers who are more than able, willing, to provide such service and help, but people just don't know about getting help so what we set about trying to accomplish last winter, was for our television station to become a conduit between the bodies of individuals wanting and needing help and that body of service-rendering agencies who were there to help.

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I asked our managing group at the television station to help us. We identified the estimated size of our aging population. All of us know that that population is growing almost geometrically. We then identified the service-rendering agencies in our city and area and we had one principal target, and that was that we felt we had to have one telephone number that could be used to transmit information to that body of people that we assumed we could get to through television.

With the magnificent cooperation of the service-rendering agencies in Tennessee and southern Kentucky, we put together a steering committee and we and they planned a television program. That is a reverse telethon. We were not there trying to raise money or were not asking anybody for anything but their volunteering the services and the help of services from agencies, representatives here this morning.

This television program was designed to provide information from experts and an opportunity for people to talk by phone through that one telephone number to experts and volunteers from agencies prepared to help.

That special 3-hour broadcast had been preceded by 3 weeks of news stories and features on our television station focusing on such topics as housing, legal services, physical abuse, medical needs, transportation and many others. The phone number used for that broadcast we called Aging: A Family Affair, was 255-HELP.

That telephone number is still in place. During that 3-hour broadcast we had approximately 1,500 telephone calls, and you were there answering some of those calls, Congressman.

It was kind of surprising to some of us, and the fact that most of those calls that we received dealt with financial issues, or dealt with Medicaid, Social Security, and we did not get a lot of calls about physical abuse, very few calls about that. That is probably because so many people are very reluctant to talk about that issue.

We learned through some news stories that much of that abuse actually happens in the home, and I am sure that is a very, very emotional experience for anyone to have to deal with before they would go public with that kind of information.

A community needs the total cooperation of every service rendering agency in that community, and in Nashville we could not have asked for more help.

We went to the senior citizens, United Way, Council on Aging, Council of Community Services, Mayor's Informational Service, the medical college, Tennessee Commission on Aging, and your office, and you were gracious enough to help us cut through some of the redtape in Washington.

You sent one of your staff to be a part of that broadcast and it made a big contribution. We felt good about what we accomplished that night, because we put into place that telephone number that people now can call for information.

If we do nothing more, we provide the service, if we simply provide an ability for people to call that one number to get the information that leads them to the solution of their problem.

Television, in particular, has a unique capacity to deal with that, because a lot of the aging people that need that help. We learned some people can't afford to buy a newspaper.

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Television has a unique capacity to provide that service. I hope if we can, we will be able to supply this as a model that other communities may use.

I appreciate your inviting me to be a part of this meeting.

Mr. BONER. Tom, I know you have some other commitments you have to go to, so please feel free to leave.

Mr. BONER. We would like to hear from our first panel comprised of three people who have experienced firsthand abuse.

Our first witness will be Mrs. Alberta Hindman who is accompanied by Susan Moreland of the victim witness division. Second will be Mrs. Mildred Mallard, also accompanied by Mrs. Moreland. And third will be Mrs. Khoury who is accompanied by Howard Scott of the National Communities Organized for Progress.

We want to thank you very much for being here and we look forward to hearing your testimony and your presentation.

I am going to ask you to speak into the microphone.

Mrs. Hindman is 86 years of age, and her throat is a little sore, so she looked at me and Bart and realized which was the older of the two, so I got selected to read this.

PANEL 1, CONSISTING OF ALBERTA HINDMAN, ELDERLY ABUSE VICTIM, AND MILDRED MALLARD, ELDERLY ABUSE VICTIM, BOTH ACCOMPANIED BY SUSAN MORELAND, VICTIM WITNESS DIVISION; MILDRED KHOURY, DAUGHTER OF ELDERLY ABUSE VICTIM, ACCOMPANIED BY HOWARD SCOTT, NATIONAL COMMUNITIES ORGANIZED FOR PROGRESS

STATEMENT OF ALBERTA HINDMAN, PRESENTED BY REPRESENTATIVE WILLIAM BONER

Mr. BONER. Mrs. Hindman has been a victim of domestic violence for several years. The perpetrators have been her sons, who have had alcohol-related problems.

One son is currently living at home and is helpful to Mrs. Hindman. Another son has had numerous charges filed against him. He currently has a bench warrant against him for failure to appear in court on charges that Mrs. Hindman has against him. He also has a felony assault charge pending against him for assaulting his brother.

Mrs. Hindman feels that the victimization she experienced has affected her life "quite a bit" in a negative way. She thinks that her years as a senior citizen are not as fulfilling as they might have been if it were not for the violence that she has experienced with her sons.

As Mrs. Hindman puts it, she feels embarrassed, not happy, and just plain disappointed. Going to court against her own children is very painful and embarrassing.

When Mrs. Hindman has experienced physical abuse from her son, she always calls Metro Police. Mrs. Hindman is pleased with the way the police have responded and handled her situation. She says that she could not cope with the violence that she has been subjected to if it were not for the justice system.

While she thinks the system does what it can, she would like to see more done in the way of assistance for senior citizens in helping them cope with this type of victimization. An example of

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needed assistance is when the court orders a son, husband, daughter, or other family member to stay away, certain measures should be taken to enforce the court's order.

Mr. GORDON. Mrs. Hindman, I want you to know that this is a difficult thing for you to come here, but I want to thank you because it is going to help others by you coming here and talking about this subject.

Mrs. HINDMAN. I appreciate that.

Mr. GORDON. Well, could you tell us how long did this go on before you went to the police?

Mrs. HINDMAN. Well, it has been going on for some time.

My son had me down on the floor almost 3 years ago and he choked me almost to death. Robert, he was there, but they are both alcoholics, and Robert, he had been mistreated.

Eugene and he kept me up last night until 2 o'clock this morning——

Mr. GORDON. Even last night?

Mrs. HINDMAN. I locked him out this morning. I said, "You can't come in. You are not allowed to stay here, and you can't stay here." I can't keep calling the police. He broke out the window. About 3 weeks ago, maybe longer, and he took my houseshoe and hit me over the head. That is when I got the warrants for him.

I went in the hospital the first Thursday of last month. He was going to stay there and take care of me. He stayed there while I was in the hospital and when I come home, he stayed there a few days, no where to go, no job, 48 years old and he hasn't worked but about 2 weeks since last July.

He is there all the time. He will cuss me, call me a liar. And Eugene, I haven't seen him since he got his disability check the first of last month. Where he is in town, because he called me and said he is going to send someone to get his check.

Mr. GORDON. These are your sons.

Mrs. HINDMAN. Yes, Eugene, he will be 54 in September.

Mr. GORDON. Do you have friends your age that have had these types of problems?

Mrs. HINDMAN. No, I don't think anyone is treated like that.

Mr. GORDON. I am sure it is rare that you have a son doing that.

Mrs. HINDMAN. Two sons.

Mr. GORDON. Are there other senior citizens that have suffered, maybe not from their immediate family but otherwise?

Mrs. HINDMAN. Not that I know of. I more or less don't have any people——

Mr. GORDON. This is not something you talk about?

Mrs. HINDMAN. That is right. They know that. They don't know a lot about it.

Mr. GORDON. If you can't turn to your own sons, what can you do?

Mrs. HINDMAN. That is what I want.

Mr. BONER. How could we best help senior citizens find help for domestic violence such as what Mrs. Hindman has suffered?

Ms. MORELAND. Be there to listen to their problems, help them work out a solution. Normally, when a person has a problem within the family they have to take decisive measures on a solu-

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tion. It has to be something they want, just as an alcoholic wants help.

When someone in a family needs help they have to want it, too. Within the justice system there is something lacking for the enforcement of court orders or keeping the perpetrators away.

There is something missing to assist the elderly in that manner.

Mr. BONER. Would family alcohol abuse counseling be helpful in a situation like this?

Ms. MORELAND. Yes, especially in Mrs. Hindman's situation, she feels like alcohol is the main culprit, because her sons are all right until they start drinking or go on a binge.

In most of the instances I have seen, alcohol is what spurs on these binges of violence.

Mr. BONER. How many reports of this would you say you have in the course of a month or a year?

Ms. MORELAND. At least 15 a month. At least 15 cases a month of this nature.

Mr. GORDON. Let me ask you, we have an 86-year-old lady here who can't depend on her sons, and her sons are her problem. Where does she go? What can she do?

Ms. MORELAND. Well, at this point we are working now to try to figure out how to keep her sons away and keep her safe.

She has become friends of the police officers. Some have been awfully good and very helpful. There have been people through the system. We have been supportive and help her figure what to do. Her health has kept her from keeping some of her court appearances, and some cases have even been dismissed because the judge wouldn't keep the case active because the prosecutor wasn't there.

At this point there is no remedy, nothing currently to tell Mrs. Hindman exactly what to do. That is something we need to continue to work on.

Mr. GORDON. Well, we want to count on you, the people that are in the field, the ones dealing with this every day. You are the ones we need to help us find the solutions. We can't on a Federal level implement magic, and we need some concrete ideas and suggestions.

Mr. BONER. Mrs. Hindman, we want to thank you for coming, for being here and telling us your problem.

Mr. BONER. At this time we would now like to ask Mrs. Mildred Mallard if she would come forward. Mrs. Mallard also has been a victim of violence, and at this time we appreciate your being here and would welcome your comments.

STATEMENT OF MILDRED MALLARD

Mrs. MALLARD. First of all, I am a restaurant owner, my partner and I, in Madison. I have been in the restaurant business for 8 years.

My husband is an alcoholic. He has also embarrassed me quite a few times at the restaurant and threatened my health.

He has abused me at home, kept me up all night. He has never beat me, but he has got drunk, kept me up all night, and he has tried to separate my children and I and my family and my friends.

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I had a duplex house in Inglewood, and I had a 64-year-old lady living with me and she had to go to work at one of the hospitals at night.

He kept her awake during the day with his obscene language and drunkenness, and going around to her apartment, peeking in her windows.

So she told me one night, she said, "Honey, I am going to have to move because I can't take this any longer."

That was her whole means of support, a woman 64 years old. I confronted him with it and asked him not to do it. She had to get the police help her to her car before she could even go to work. After they come out of there they told her they would have to take her down and get a warrant for his arrest. If they could have took him right on then, I could have got a good night's sleep anyway, because he kept me up the rest of the night.

Then I asked her, and I told her, I said, "Don't worry, Idy, I am going to get me a divorce and I will sell my home and if I can help you in any way, I will carry you with me or I will do anything I can to help you."

He said he was going to beat the hell out of her. That is what he used—and he walked around the neighborhood drunk. We lived at this one place 8 years. I got an inheritance from my brother. I was 58 years old when I started my own business. I have been a waitress for 40 years and loved every minute of it.

I think, jealousy, he tried to separate me and my children, which we have always been very close. My brothers quit coming to see me. They would come to the restaurant to see me but that is it. It was on account of him.

That had been going on for a long time. I should never have let it go on but I did. It was kind of embarrassing to go to court and get a divorce, all this stuff.

A week before Christmas, I was at the restaurant and my partner Susie Dalton—which I could never have done without; she is great—and we had started down the little slope in there, and I broke my ankle, which was, I told her, I said—she helped me up, and "Let's go on and do some Christmas shopping." My ankle was hurting so bad I had to go to the emergency room. He was sitting out in the truck drunk, the morning after he caused this lady in the duplex apartment all that trouble.

She carried me to the emergency room, and I got my leg, ankle in a cast. She brought me up, two steps up the back, and she was trying to get me up on crutches and I fell. And he laughed and he drove off. And she picked me up. We both fell up the steps, and I thought I was having a heart attack right there. But she got me a glass of water.

He stayed drunk for 3 months, and I had my leg in a cast, so the last thing that brought me to the breaking point was he pulled a gun on me. I was talking to my granddaughter; my grandchildren are great; I have three that work in our restaurant. And I was talking to her on the phone and I said, "Oh, Jennifer, Bob has a gun. He is pointing it at me."

She says, "Grandma, hang up, call the law."

He said I had the gun but they knew better. They got the gun. But I think they took him on in. But it was raining and I can't

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hardly drive at night. I think if we had something that the law could take them, if they see that you are being abused, right then at a certain age or over, that they could take them on in, where you didn't have to go down to the court and sign and get a warrant out for them, that would be great. I couldn't keep up with him going down there. I am not a fast driver and I am too nervous.

Then he has—we have a great police force in Madison. My beautician, I have had to call her over that night. Four years ago I took an overdose. He had me to the breaking point. That is when I got in with my partner, Susie.

If it hadn't been for her, older people, senior citizens, I would probably already be dead. That is my story.

Mr. GORDON. Did you have these type problems when your husband wasn't drinking?

Mrs. MALLARD. He is awfully jealous.

Mr. GORDON. Is alcohol the bottom problem in all of this?

Mrs. MALLARD. Yes. If I had a lady friend, Susan, he would call us "lesies," and you believe it. The next day I would be a man—it was hard for me to decide?

I have a good family, real support from my family. I have good support from my children, my lawyer, my doctor. He is great. Everyone, they should go to their doctor and let them know the situation and feel free to call him because he wants to help you medically and he wants to give you moral support. My doctor and his wife have even invited me out for lunch on different occasions to talk to me. It makes you feel really good.

Mr. BONER. You don't look your age.

Mrs. MALLARD. I am 65.

Mr. BONER. What was the age of your husband?

Mrs. MALLARD. He was 58, and that was a mistake. He is on 100 percent disability. I guess I really felt sorry for him. My heart is bigger than, I don't know—you know, I am from a big family, 14 brothers and sisters, and I have 8 brothers and you know what I had to put up with when I was growing up.

Mr. BONER. Do you feel more vulnerable because of your age, what is happening to you?

Mrs. MALLARD. No, because he is older, really, than I am, when it comes to working. He is not supposed to work, but I love to get out and mingle with my people. I love my senior citizens. If I am out there on Sunday, my partner won't let me stay away from there; she makes me come down there, bless her heart.

Mr. BONER. Are you aware of other older women in situations such as your own?

Mrs. MALLARD. Yes, and I would love to call them. I would love to help them. At 58 my brother left me an inheritance and it got me started. I took my money and used it wisely and now I would love to help someone else like he helped me.

Mr. BONER. If there were a group counseling or therapy session, if you will, where people who have experienced similar problems could gather together to discuss these, you feel like strength could be gathered from everyone talking about their problems and how everybody is dealt with?

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Mrs. MALLARD. I really think so, and it would help a community if they had a gathering place to go, and discuss all this. And I would be glad to furnish the food.

Mr. BONER. One last question.

What type of increased community support in your particular situation would you like to see that would be most helpful to some of the folks who have been in a similar situation such as yours?

Mrs. MALLARD. First, I think they have to seek help and let it be known, because I tried to hide mine, and the more you try to hide it, the worst off you will be inside. I wouldn't go to the restaurant for 2 years.

Mr. BONER. How did you know where to get help?

Mrs. MALLARD. Well, my doctor and then my partner, she made me get out, and my doctor, my beautician—I have been going to her for several years, Jeannette Perry. She has a beauty shop in back of the restaurant, and I have called her at 12 o'clock at night and she has been to see me. It felt real good.

Mr. BONER. Have you been able to call on Susie?

Mrs. MALLARD. Every day, any hour of the day or night I can call on her. She's got a great husband. She's known me for 35 years.

Mr. BONER. What about the victim-witness program; have you been able to take advantage of Susan Moreland?

Mrs. MALLARD. She's been awfully sweet. I haven't yet but I would love to.

Mr. BONER. Where are you as far as the status of your husband?

Mrs. MALLARD. We are getting a divorce.

Mr. BONER. Do you fear for your life?

Mrs. MALLARD. Yes, but I am not scared. I feel like he might—I sold my home, moved into an apartment, and the people there, I live at Greybrook Manor, and they—I have told them my situation before moving in there, you know. I wanted them to know before I moved in; they might not want me in there. We have 24 hours' security in there.

Mr. BONER. Since you moved in, have you had further problems?

Mrs. MALLARD. Yes. He calls me on the phone. He keeps me up all night like he used to, but it is on the phone now, not in person.

Mr. BONER. That is good.

Mr. GORDON. Obviously you have been through a difficult situation but are handling it well. You mentioned earlier that there was a time in your life when you thought about taking your own life. Was this when you were trying to keep all of this into yourself?

Mrs. MALLARD. Yes, 4 years ago.

Mr. GORDON. When you finally came out and let folks help you, talk about it?

Mrs. MALLARD. It really helps. If I had been about 1 more second—my brother came in and saw me there.

Mr. GORDON. Even though you are still receiving the abuse now, now that you have help you can handle it; you would never think about committing suicide?

Mrs. MALLARD. Oh, no. I would call my doctor, my friends. The way I had to live with him, I was losing my family, my children.

Mr. GORDON. The message that we are learning here is that to survive this, you got to put it in the open, share it, and I hope——

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Mrs. MALLARD. You got to have somebody to share it with you. They might not have been through the same thing but they can give you help.

Mr. GORDON. Your talking about it will make it easier for other people in the future. Hopefully somebody else's lives will be saved like yours was.

Mr. BONER. Now I would like to call on Ms. Khoury. She will be accompanied by Howard Scott. For the benefit of those who are here, after we have our three witnesses who will speak to us, if you would like to ask questions, we are going to do the best that we can to work that into the time restraints that we have.

Mrs. Khoury, welcome to our hearing, and we look forward to your testimony. If you have anything in writing, we will make sure it is in the record.

STATEMENT OF MILDRED KHOURY

Mrs. KHOURY. Thank you.

My name is Mildred Khoury. I have been a resident of Nashville all my life. I would like to thank the members of the Subcommittee on Housing and Consumer Interests for this invitation to speak here today.

I would like to say that I am here to speak about a serious moral issue—the abuse of elderly people, especially in nursing homes. My mother passed away a year ago March. For 3 years prior to her passing, my mother was a nursing home resident. Due to her strokes, heart problems, and inability to feed or control herself, I was no longer able to give her proper care at home, and she was admitted to a nursing home in Franklin, TN. Later, upon realizing the bad treatment she was receiving there, we moved her to an inner-city Nashville nursing home where Medicaid/Social Security patients could be admitted. I want to tell you about the conditions she and others faced in these facilities.

It is difficult in 5 to 7 minutes to tell the hardship so many of these elderly Americans are subjected to in these substandard nursing homes. I might say that many people here in Nashville, like the NCOP, and across Tennessee have been fighting to bring about better care and better treatment for these elderly people, but we must have the help of our government and our representatives.

I visited my mother every day in the nursing home except when I was sick. Then I would send friends. I visited at different times of the day to see if she was being fed properly, given proper medication, cleaned, groomed, and treated respectfully. I think it is entirely fair to say that nursing home residents with no one to visit them are given far less attention than those who have regular visitors.

These are some of the abuses of the elderly that I can report to you from the two nursing homes mother lived in: My mother was left lying in waste and urine overnight to the point where her skin was red and blistered. Other patients in these federally paid facilities were left in this condition to the point of getting large bed sores.

My mother was sent to the hospital to get stitches in her head due to falls in the nursing home, where patients were not given

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proper support and floors were often soaked and slippery with urine from other patients.

My mother was restrained and tied to her chair for many hours at a time. She was diagnosed as having a strangulation hernia and was not supposed to be restrained without her hernia belt—I just brought two of them because the rest of them were thrown away by aids or nurses—but she was due to lack of knowledge of nurses and aides. I have seen other patients tied in bed who have tried to get out, wiggled their way down to the end of the bed with the straps so tight around them and become trapped for long periods of time.

My mother was overmedicated on several occasions to the point where she would go into a deep sleep and could not be aroused for up to 24 hours. Some medication nurses did not know how to read dosages. I finally requested that her medication be given in pill form. What I am talking about, she was given concentrated medication, and the nurses could not tell the difference.

Medication was not always given on time. Sometimes when medication was several hours late due to lack of help, the next dose would be given shortly afterward. The records would then say the patient got all their medication, but in reality the patient was overmedicated.

Mother's food at the nursing home was unbearable most of the time. I have seen waterbugs on her food and in the coffee. Patients who were diabetic or needed soft food were given the same food as the others. Patients who need to be fed were not fed, or hurried. Once when mother was unable to chew her food, she was put in a cold shower and sprayed in the face and told, "By damn, you will chew your food or else." The aide who reported this was fired. The aide who did it is still working there.

Water was not served to patients on many occasions. Most of the patients taken to the hospital from the nursing home that I knew about went because of dehydration and malnutrition. When the nursing home knew of a State inspection coming up, good food was served and patients given plenty to drink.

Personal property of the patients, including my mother's, was not respected.

And I am sorry to say that on one occasion, my mother was sexually assaulted by one of the mentally ill male patients at the nursing home. We have State documents here to show, and I have some with me today.

We have been in groups to the State government hearings and presented this testimony, but these pleas were not recognized.

I thank you for your attention and hope these facts may help to bring about an end to the terrible abuse of the elderly that is going on today.

And, in closing, I would like to read to you a poem that my mother wrote before she became ill that I found in my son's Bible. This may be food for thought for some of you who would want your parents to live their final years in dignity. I was moving and going through books, and my mother was always putting little notes in, recipes and what have you, and I found this note in my son's Bible for a reason. Why I don't know, except to make me feel better.

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I would like you to listen intently, because I think this will give you some food for thought.

To Mildred, I had no college degree. Once I was told that the greatest university in the world was not enclosed by four walls, but by an inquiring mind, a loving heart, a willingness and eagerness to learn and by a deep faith in God. To these I would add a dictionary and access to a public library.

I do not feel I am indispensable, certainly my part in great drama of life is small, like a pebble carelessly tossed into a whirling pool. For a moment only the rhythm is disturbed.

When I am dead the snow will still fall in winter, the trees will still bud and put out new leaves in springtime. Autumn will follow Summer and the leaves will drift noiselessly down as they have unnumbered centuries, but I have lived in vain.

For a little time my children will grieve for me, but I would not have their grief to last too long. I would have them think of me as walking the hills of heaven, greeting old friends, and making new ones, looking for my share of gold, not in shining payments, but in blossoming daffodils or goldenrod, happy to be in the presence of my God.

I leave behind children and grandchildren with a deep and sincere faith in God. Mother.

I thank you for your attention. I hope these facts may help to bring about an end to the terrible abuse of the elderly that is going on today. Thank you.

Mr. BONER. What role does the State's Nursing Home Ombudsman play in helping?

Mrs. KHOURY. Ombudsman, I say, I think is doing a fine job. I am really proud of ombudsman. My contact with ombudsman has been Mary Lee Stills, and she has followed up on complaints, and I am happy to see we have had Mary Lee here and I have had the confidence I have.

Mr. BONER. What about legal services?

Mrs. KHOURY. Frankly, no.

Mr. BONER. Have you called on them for help?

Mrs. KHOURY. Yes.

Mr. BONER. What was their response?

Mrs. KHOURY. It was a family problem, not a nursing home problem.

Mr. BONER. What more do you think could be done to help those in nursing homes protect themselves against this type of abuse?

Mrs. KHOURY. Bill, these abuses have been going on so long, and we as community groups, Nashville Community's Organization for Progress, the Gray Panthers, East Tennessee Coalition, we have all been to the hearings. We have presented testimony. We have gone to the State legislature, and we have been totally ignored, and the reason that I was happy that I was invited today, if we are not going to have State cooperation to the fullest, then our Federal Government will have to come in and help us, and I feel this very strongly. We have been totally ignored, in other words, by the State.

Mr. BONER. In Washington, members of the Aging Committee have introduced a bill that is referred to as the nursing home rights bill, to provide residents with increased State protection and with an assurance of the rights of residents to live with dignity in the nursing homes. I know that the comments that you have made will be welcomed and received by those on the committee, as this bill progresses forward in the legislative process.

Thank you for taking the time to be with us.

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Mrs. KHOURY. Thank you.

Mr. BONER. I want to thank each one of our witnesses on the panel for participating. I know it takes a lot of courage for you to come here today, and we appreciate your participation.

Mr. BONER. Our next panel consists of two witnesses, and these gentlemen are very knowledgeable in this area, and we are honored to have their presence here. The first panelist will be Dr. Curtis Clark, and then William M. Stephens. If you have a written statement, give that to us, and it will help us to have your remarks reported as accurately as possible.

PANEL 2, CONSISTING OF CURTIS CLARK, M.D., DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF TENNESSEE, MEMPHIS, TN; AND WILLIAM M. STEPHENS, ATTORNEY AND COLUMNIST OF "ANSWERS ON AGING," MEMPHIS, TN

STATEMENT OF DR. CURTIS CLARK

Dr. CLARK. Mr. Chairman, I appreciate very much being allowed to appear at this hearing concerning the problem of elderly abuse that affects at least 10 percent of those persons 65 years of age or older. This is a very complex problem, and it is of a very serious nature, particularly to those who are affected either by being abused or by being allowed to be the abuser. I appreciate very much being privileged to be here and hear these people testify, and the human drama.

I would remind you that a very minimal, at the very minimum, this occurs 1 million times per year in America. It is my personal opinion, after having worked with this, that this is only the tip of the iceberg. Much more research is needed to be done, and I am hopeful in this State that we are now getting into a position where we can do this.

I have been interested in this area for over 30 years, having been privileged to work in a medically deprived, economically depressed area for some 22 years with very little support system for the elder citizens, though at that point in time the only real services available to me were the support and caring that came from the lady who was head of the Department of Human Services in that county. This, by the way, was a rural area in central Arkansas.

Some 8½ years ago, I changed my professional direction and took a position with the Department of Family Medicine in a community-based residency program in Jackson, TN. It was here that, through some encouragement from a professional nurse who worked in an emergency room and asked me to assist him in making a presentation on elder abuse and I was impressed by the time that I had been consulted by our young physicians in graduate training who needed assistance with elderly people who were being abused in some manner, those were the two instances that started me to thinking about some of the things that would come into reality over the next few years.

It was about this time, in April 1980, that Representative Geraldine A. Ferraro made a presentation on domestic violence against the elderly. To my knowledge, this was the first presentation before a congressional committee in Washington as it relates to this social problem. One of the presentations that I had used is

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very descriptive and fits very well today the things that you have already heard.

I would quote, her opening remarks are an accurate statement concerning this problem, and I have spent a lot of time, effort in studying this, and I quote "At the same time, I urge the Congress, the social services providers and the American families not to overlook this serious problem."

Statistics indicate that domestic violence against senior citizens is occurring with a large frequency, and it is increasing. I am concerned that the failure to improve services for these victims will only increase our nursing home population and increase the numbers of senior citizens who are physically and mentally damaged.

I, too, suffer from the same time restraints that all of the other persons who are testifying do. I have a presentation that takes from one hour to an hour and a half, a slide picture presentation of what we have been doing over the last 8 years, and I have a deep concern that I will not be able to adequately explain this to you. I do not think it is impossible in this length of time, but I began to notice that we were being called upon with increasing frequency to take care of the medical needs and also serve as an advocate in this area.

It was at this time that it became very obvious to me that I was not only responsible for serving as a medical advocate for these persons, but I felt that the physician had a responsibility to serve as an advocate in an area that was new to the role of the physician and other health care professionals.

During this time it had become all the more obvious to me that I could not cope with this situation alone and had begun to talk with other health care professionals that I would have to consult in order to resolve these circumstances. I asked if they would care to become associated in a geriatric abuse intervention team. After two brainstorming sessions with these individuals, it was decided that we would in fact form a team and work together to serve our patients in a broader and more effective manner.

We worked for approximately 2 years in serving our patients without really being noticed in the community simply because this is not a problem that is to be used other than of service to those in need. We felt that we should be allowed to work unmolested for a period of time in order to determine in our own minds and hearts if this was an appropriate approach to this situation. Through the years, the team has changed as persons have moved from the community to other areas, but we still have several of the original persons who worked on the team continue to work in continuity in this area.

I am very pleased that there are some 10 or 11 teams now working across the State that have been coined and followed the team that we set up. I would like to present to you a thing that I have given purely as an introduction to one of my presentations, and I think that this will give you much of the information that you need. I took the opportunity to present articles that have been contributed in this area and only through that will you be able to fully understand my position from this.

A recent study by the University of Maryland indicated that abuse of the elderly, particularly by their children, may well be as

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severe a problem as child abuse. Marilyn R. Block, a researcher to the Maryland Center on Aging, feels that the plight of the battered parent has gone largely unrecognized.

The abuse of the elderly is more difficult to identify than spouse or child maltreatment. The older person is more isolated, less visual, and, therefore, his abuse is less obvious. And abuse of the elderly is now at the stage where child abuse was 20 or 25 years ago. And in 1978, a study performed by Dr. Kostburg found that almost 10 percent of 404 clients 60 years old and older had been abused in some manner. Although this was not the reason they had come to the attention of the agency, three-fourths of the patients had been physically abused; and more than one-half had been psychologically abused.

It was apparent most patients have had multiple types of abuse. This is what we have found. We rarely found only one area where a patient is abused. Many have been infantilized, threatened, terrorized. Some had lost moneys, their homes, and their rights as an individual in our society.

In the geriatric abuse survey of 135 professionals, not one response came from a physician. This is of a great deal of concern to me, because I am responsible for at least the postgraduate training at this time. I had the privilege of helping train some 56 physicians that are now, one of them just moved into an area that I passed last evening, very close to Nashville, who will be a great advocate for the elderly.

The other data that I have surveyed indicates that we as physicians are the least likely to suspect abuse. This makes all the more reason for me to be interested in this problem, since I am involved in the residency teaching program.

The average person most likely to be abused, according to limited data, suggests that the typical person is 84 years of age, female, Protestant, lower or middle class and living with relatives.

I am not one who likes to point up problems without giving solutions, but I think that I ran into a situation—I hope because this is my basic personality—but I ran into a situation yesterday, some persons I have a great deal of respect for, that points up part of the problem.

You can point your finger at me as a physician, as a caretaker, for maybe not always being right, doing all I could humanly do for someone, and I think all of the elements of society—society is as much responsible for this as government, the abuser, because we fail to educate ourselves, and we have not shown the human care that we need to.

June 30, 1986, a report, what I believe I would be able to do is not to incriminate anyone, and we are going to have some counties mentioned here, the counties will be called blank and unnamed. A report from Beth Daley, social worker, Jackson/Madison County, General Hospital, and "Blank" County DHS was contacted concerning a patient presently in Jackson/Madison County General Hospital. The request was made to check out the living conditions of the patient, abuse and/or neglect was suspected. The request was made June 20, June 20, with the phone number of Jackson/Madison County General Hospital being left for report to call back.

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On June 24, 4 days later, no word having been received, a call was made back to "Blank" County, and the report was that the request was to be on the superior or was on the supervisor's desk, not been assigned to anyone. On June 30, it was learned by another phone call that the referral had been sent to "Unnamed" County, since the patient lives on the county line.

When "Unnamed" County was called, it was learned that the case had been sent back to "Blank" County because the patient's house was in "Blank" County. "Unnamed" County did not receive the referral until June 27, at which time it was referred back to "Blank" County. To date, nothing has been done concerning this request of Jackson/Madison County General Hospital.

Many of these persons do not have 10 days in which they can be protected. They need it now.

I heard these persons testify, how helpful law enforcement officials are, and they certainly are. One of the most dedicated people I know is a police officer who has gone to hearings, meetings, and he knows the people that come before our geriatric center, and he knows their social history, all of this.

I simply point this up to day, and I believe Hank Williams, Jr., has a song that has some words in it, "Attitude Adjustment."

Now, these persons need an attitude adjustment. Society needs an attitude adjustment. Pardon me for saying so. Our governmental bodies, all of them, need education, and attitude adjustment.

I cannot do it alone. The dedicated people that I work with in Jackson, TN, that is in west Tennessee—foreign country to many of you—we cannot do it alone. I want to say on behalf of these persons that are very dedicated individuals, they have never made a dime for the work that they have done. The only thing that they get for it is the good feelings they get in their emotional well-being and in their heart.

I would like to thank the University of Tennessee for allowing me to work in this area, particularly the Department of Family Medicine, Department of Human Services through the State have supported us, and even—I appreciate my wife who has allowed me to be absentee husband for this time and I would be most happy to answer any questions that I could possibly answer.

Mr. BONER. Dr. Clark is the assistant professor with the Department of Medicine at UT, Memphis, and he joined the staff after 22 years of private practice and helped develop the GAIT, and served with many elderly advocacy groups and written articles and addressed the subject of elderly abuse. He has to shortly be on a TV program on channel 4. Any questions anyone would like to ask of him?

Dr. Clark, can you briefly relate some specific instances where the geriatric abuse intervention team has intervened in some cases of elderly abuse?

Dr. CLARK. We have worked somewhere between 150, 200 cases over the years. I regret that I am not able to use the slide presentation, because I have documented cases, cases dealing with the patient where the police have documented. You know, a picture is worth a thousand words.

I am not very good at drawing word pictures. I could mention hurriedly, Mr. and Mrs. T, who live in a deplorable condition, and I

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made a house call to this home, and the filth is unimaginable. He had large ulcers on his legs infected with maggots. The wife had a mental problem and the Department of Human Services went in, and I am not here to grind the axe of the Department of Human Services, even though I presented one situation that is not very complimentary, but a thousand things they have done appropriately, and very well.

I respect and understand the test concerning the nursing home, and I would like to say here that many, many things, and I wish I could share a couple experiences I had with you of cases that we followed in the nursing home of abuse now, actually the people I had reason to visit them yesterday, they have been followed for some 6 years.

This gentleman and his wife were taken into custody by the Department of Human Services. His wife and he fought consistently, all the time. She is now in a nursing home.

He has been—gotten needed surgery, now living at home, and is doing very well.

Another one is a situation, Mrs. B, that was brought to our attention. This lady had had strokes, living with her son and his friend. This lady's son's friend and possibly the son. I interviewed this lady. They had been choking her and this is documented, proven, and this lady was very frightful and we were able to put her in a nursing home and allowed this lady to die with dignity.

This one case, I believe, to fully expand on it would take me an hour.

Mr. BONER. How do you pinpoint cases of elderly abuse?

Dr. CLARK. It is probably one of the most difficult things as a physician to be able to diagnose. Persons are embarrassed, ashamed, and they feel they have no way out, so they choose to live in these circumstances.

Physicians are trained to diagnose medical problems with a high index of suspicion. If you see someone that has not taken their medicine, someone may be stealing their Social Security check, we see that. Someone may not be complying or coming to see the doctor, as they need to.

This is the reason for it. You may find possible behavior. You have to have a suspicion. There, again, the persons who are most helpful are those persons that are engaged in social work, either private or other types of social work.

MEMBER OF THE AUDIENCE. Does he help in the nursing home abuse?

Dr. CLARK. Oh, yes, I help investigate many cases of nursing home abuse. Only the human imagination—I have seen financial abuse, sexual abuse, physical abuse, emotional abuse.

MEMBER OF THE AUDIENCE. What are you doing about it?

Dr. CLARK. Well, there is a statement that, I am harmless as a doe, but stubborn as a bulldog.

It takes a great deal of intestinal fortitude to stand up sometimes in these situations because I have been threatened, accused of murder. I have been threatened by persons. I have been harrassed at home. I have been threatened with physical violence, just about everything you can imagine, and it takes a commitment, I will

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have to say that, and this is part of the problem that persons just don't want to get involved.

MEMBER OF THE AUDIENCE. That is right, but if you want to get involved, can you do it by yourself? What can they do, because we fight, and there is nothing you can do?

Dr. CLARK. I have a workable solution that has worked 8 years, and this is the Geriatric Abuse Intervention Team, a group of health care professionals, and you can use housewives, attorneys, police officers, and nurses. There is some very definite criteria.

There has to be a caring on the part of the individual, and a commitment, and I say it kindly, but you have to be very stubborn, and I am not going to sit here and tell you that we have solved every situation that came to our mind, or came to our attention, but I think we found reasonable solutions for everyone of them.

I don't know of a one that we have ever turned and walked away from.

MEMBER OF THE AUDIENCE. You said earlier that one of the cases you worked on, the lady was put into a nursing home, was allowed to die with dignity while she was there. How many of those cases are there in comparison with the cases of abuse in nursing homes that you have followed up on? Do they balance out?

Dr. CLARK. I never thought of it in that term. I think that it is about balanced out.

I wish I had time to share with you the two experiences that I had followup on people that we worked with for some 6 years in a nursing home. Again, I say, many, many, and I don't want to say everything negative, because support from families are tremendous with the elderly that I work with. It is only that, I fear, more than 10 percent that is documented. We need education, research, and we need commitment.

Mr. BONER. Thank you very much for your participation, Dr. Clark.

Mr. BONER. Next is William H. Stephens. Bill is now a practicing attorney in Brentwood and was previously director of legal care, Tennesseee Commission on Aging. He is also the columnist of "Answers on Aging," a weekly column which appears in 17 newspapers and 3 senior citizen monthlies. He is the author of many publications, and is a member of both the Tennessee State Bar and the U.S. Supreme Court Bar.

Bill, we are glad you are here.

STATEMENT OF WILLIAM M. STEPHENS

Mr. STEPHENS. Mr. Chairman, I am delighted to be here and to have heard these moving presentations.

I don't like to start out by pointing a finger, a couple of the anecdotes he told, they prompt me to say I can top that one.

Three different times when I was working with the Tennessee Commission on Aging, I received referrals from the White House where individuals had written directly to the President, and one case involved financial exploitation. One case, a lady was about to lose her home, a foreclosure, and another case involved Alzheimer's disease. In these three cases it took an average of over 6

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weeks before someone at the White House picked up the phone and called the Tennessee Commission on Aging.

One was over 60 days. I know there are dedicated people in the White House, just as there are in the Department of Human Services, and in every agency, all the State legislature, nursing homes.

I have seen a number of abusive situations in nursing homes, too, and family situations where members of the family have ripped off the older person's estate becoming conservator or guardian or getting a power of attorney from the older person who didn't have the capacity to execute a document. These conditions are terrible. It is a mistake to think that we can solve these problems merely by more effective information referral services, although these are very important.

I was fortunate to participate in the Channel 5 special, and was down there answering the phone until 11 o'clock at night, about an hour after it went off the air. It was very rewarding.

It has improved the referral program. However, I have received many referrals from this aging help line, when I was not the appropriate person but they didn't know who else to call. There must be education, better referral systems, more dedication.

That is not enough to solve the situation where an elderly person has no relative, no friend, to help her with her personal affairs or financial affairs.

This is a very, very common problem, as all of you, my friends, I recognize and know a lot of you who are connected with various agencies. Jackie Beery-Day, who is going to succeed to my job at the Tennessee Commission on Aging has been with Legal Services for a number of years, and I know she has been personally involved.

She has worked as conservator, balanced elderly person's checkbooks, gone beyond the call of duty as many of you have, and people in all agencies do, whether it is the Social Security Administration, or Adult Protective Services, but there are a lot of failures, too.

I had a situation I have to relate, if I may. There was a woman who telephoned me, about the age of Mrs. Hindman, and she had a similar problem. Her son would beat her up. She didn't have the same positive results from the police department that Mrs. Hindman had.

She said, "The police come out, they put me back in bed. They don't ask me one question about what happened. They go out in the yard and talk to my son, and then they get in the car and leave. Nobody even asked me what happened." She, who is crippled, said, "Through the grace of God and my minister, I finally was able to get down to the courthouse and swear out a warrant against my son. He had gone too far."

"Time passed. Nobody told me when to come into court, nobody told me anything." The same day she called me, she said, "This morning I found a crumpled piece of paper that had fallen out of my son's pocket when he left and I saw it was a summons for him to appear in court today. It was a case where I had sworn out the warrant and nobody had told me."

"I began calling telephone numbers at the courthouse. I called 46 numbers," she said, "and nobody was able to help me. I wanted to

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postpone the case until I could get somebody to pick me up and take me."

There are all kinds of failures in this situation. It is a tragedy.

My last official duty of any significance at the Tennessee Commission on Aging was to draft legislation creating a public guardianship program for the elderly in Tennessee.

This program officially goes into effect today, and Mrs. Beery-Day will be directing it. Most States don't have any program like this. It is needed so desperately because of all those people who don't have a friend or relative to give a power of attorney to, nobody they can trust.

The relative is abusing them, exploiting them. With a viable public guardianship program, we will have an independent, unbiased person who is available to serve as guardian, conservator, representative, whatever is needed.

This program is just beginning. $400,000 for the State of Tennessee, about 50 cents, or less than 50 cents for each elderly person and yet we know about 20 percent of the elderly people in Tennessee are below poverty level, a large percentage are being abused, but this is a beginning, and I submit, Congressman Boner, that the Federal Government could help measurably in this problem we are all discussing by stimulating programs of this type through the country, legal services for the elderly, separate from the Legal Service's Corporation, and we need this kind of a program and we will have it now in Tennessee.

It will make it possible for elderly people who have no one to call upon to do these things to receive services.

Thank you very much.

[The prepared statement of Mr. Stephens follows:]

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PREPARED STATEMENT OF WILLIAM M. STEPHENS

Mr. Chairman:

From 1980 to 1986 I served as Director of Legal Care for the Tennessee Commission on Aging. During this time I coordinated the work of ten senior citizen law projects and also wrote (and still write) a syndicated newspaper column appearing in newspapers throughout the state. On the average, I have received literally hundreds of letters and telephone calls each month from elderly people with problems. Many of these problems involve abuse, neglect, or exploitation.

In 1984, a group of us from various state agencies concerned with elderly problems formed a loosely knit group called Interagency Committee for Aging and Protective Services (ICAPS). One of our aims was to improve protective services for older people, and our work led to sweeping improvements in the protective services law.

For the past few years, we concentrated on the need for public guardianship for elderly Tennesseans. Although the Department of Human Services (DHS) handles about 240 adult protective services cases each month, DHS has adopted a policy of non-involvement with conservatorship or guardianship matters except when there is imminent danger of death. Because of this, many persons felt that a statewide program for the elderly should operate through the Commission on Aging.

Consequently, one of my last tasks at the Commission on Aging (before I resigned to enter private practice) was to draft new legislation creating public guardianship for older Tennesseans. To our delight the bill passed the legislature and, effective today, July 1, 1986, becomes law. Ms. Jackie Beery-Day, a remarkable champion for older people who is testifying here today, will develop and coordinate the new guardianship program. People from all income levels will be served by the program. Court costs will normally be paid from the person's estate, unless he or she is indigent, in which case the costs will be paid by the program.

The Commission on Aging will implement this new program through its nine Area Agencies on Aging. Each area agency will set up a program in its own development district and will monitor its work in accordance with policies and guidelines issued by the Commission on Aging.

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Congress could effectively aid the states, and be of immeasurable benefit to needy elders, by providing Federal funding to public guardianship programs designed to serve the elderly. The abuse, neglect, and exploitation of senior citizens is a national disgrace, and steps should be taken on a national level to alleviate and lessen the problem.

(Copy of Tennessee Public Guardianship legislation enclosed).

PUBLIC CHAPTER NO. 895

SENATE BILL NO. 1735

By Hicks

Substituted for: House Bill No. 1723

By DeBerry, Jones, Turner, L. (Shelby)

AN ACT To create a statewide public guardianship program for the elderly to be administered by the Tennessee Commission on Aging; to provide for a public guardian for the elderly in each development district; and to amend Tennessee Code Annotated, Title 34.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 34, is amended by adding the Public Guardianship for the Elderly Law as a new part. 34-7-101

SECTION 2. The General Assembly recognizes that many elderly persons in the state are unable to meet essential requirements for their physical health or to manage essential aspects of their financial resources. The General Assembly finds that private guardianship is inadequate where there are no willing and responsible family members or friends to serve as guardian and where the disabled person does not have adequate resources for the compensation of a private guardian, or to pay legal and court costs. The General Assembly intends through this act to establish a statewide public guardianship program to aid disabled persons over sixty (60) years of age who have no family member or friend who is willing and able to serve as conservator or guardian. 34-7-102

The General Assembly intends to promote the general welfare by establishing a public guardianship system that permits the disabled elderly to determinatively participate as fully as possible in all decisions that affect them; that assists such persons to regain or develop their capacities to the maximum extent possible; and that accomplishes such objectives through the use of the least intrusive alternatives. This act shall be liberally construed to accomplish these purposes. It is the intent of the General Assembly that nothing contained in this act will affect the powers of the court under Tennessee Code Annotated, Title 34, Chapter 4, Parts 1 and 2, nor create additional powers not contained therein. The District Public Guardian shall not serve in more than one capacity in any one proceeding under Tennessee Code Annotated, Title 34, Chapter 4, Parts 1 and 2.

SECTION 3. A statewide program to provide guardianship for the elderly is created and will be administered by the Tennessee Commission on Aging, which shall adopt policies and may promulgate rules to govern the operation of district public guardians within each development district, and implement the law. The Commission on Aging shall provide a coordinator to monitor program development and operation, and shall contract with its nine area agencies on aging whose staff shall serve as District Public Guardian in each development district. 34-7-103

SECTION 4. 34-7-104

(1)(a) The duties and power of the District Public Guardian shall be as follows:

To serve as limited guardian, guardian ad litem, adversary counsel, or conservator under the "Limited Guardianship Proceedings for Disabled Persons Law" or the "Conservatorship Law of 1968" as set forth in Tennessee Code Annotated, Title 34, Chapter 4, Parts 1 and 2, respectively, for persons who are sixty (60) years of age or older who have no family members or

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other person, bank, or corporation willing and able to serve as a limited guardian or conservator. The court must appoint the District Public Guardian to serve as limited guardian, guardian ad litem, adversary counsel or conservator as the case may be, in each court proceeding.

(b) The District Public Guardian shall not have any power or authority beyond that set forth for a limited guardian, guardian ad litem, adversary counsel or conservator as set forth in Tennessee Code Annotated, Title 34, Chapter 4, Parts 1 and 2.

(2) The District Public Guardian may employ sufficient staff to carry out the duties of the office.

(3) The District Public Guardian may delegate to staff members the powers and duties of the office of District Public Guardian except as otherwise limited by the law. The District Public Guardian retains ultimate responsibility for the discharge of required duties and responsibilities.

(4) A District Public Guardian shall not commit a ward to a mental facility without an involuntary commitment proceeding as provided by law.

(5) A District Public Guardian may accept the services of volunteer persons and organizations, and raise money to supplement operating costs.

(6) If the ward is indigent under SSI guidelines, no charge will be made against the ward's estate for court costs or fees of any kind. Court costs, filing fees, and other charges may be awarded from the assets or income of wards who are not indigent. If the ward is indigent, court costs will be paid by the public guardianship program.

(7) All funds received by a District Public Guardian shall be handled as state funds, and they shall be accountable as all other state funds and shall be audited annually by the state. All earnings on the funds shall inure to the benefit of the ward.

All other assets received by a District Public Guardian shall be handled as state property except that the guardian may dispose of them in the exercise of the guardianship free of laws governing the disposition of state property and shall keep a record of the disposition of all such property and the reason for the disposition.

Upon termination of the guardianship, all assets remaining in the estate shall be paid over to the ward or to the ward's legal representative.

(8) When the District Public Guardian learns of a family member or friend, other person, bank, or corporation who is qualified and willing to serve as guardian, the District Public Guardian shall petition the court for appointment of a successor guardian.

(9) When a person is appointed successor District Public Guardian, he or she immediately succeeds to all rights, duties, responsibilities and powers of the preceding District Public Guardian.

(10) When the position of District Public Guardian is vacant, subordinate personnel employed under subsection (3) shall continue to act as if the position of District Public Guardian were filled.

(11) A District Public Guardian shall not be required to post bond in individual cases.

SECTION 5. Costs of public guardianship for the elderly will be met by annual appropriation to the Tennessee Commission on Aging. 34-7-105

SECTION 6. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

SECTION 7. In accordance with Article II, Section 24, of the Constitution of Tennessee, this act shall be null and void unless there is a specific appropriation included in the General Appropriations Act to funds its estimated cost.

SECTION 8. This act shall take effect on July 1, 1986, the public welfare requiring it. Effective date 7/1/86

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Mr. BONER. What would you like for me to take back to my colleagues in Washington as to what the Federal Government could do to assist in this problem?

Mr. STEPHENS. I think what you are doing is going a long way. We need more programs to get more people, such as these people who have testified, to go public, tell their story. It takes a lot of courage. We need a greater emphasis on elderly problems.

A lot of these problems are not unique to the elderly, of course. Just this last week, as a result of my column which appears in newspapers all over the State, I had a woman write and say it is not just the elderly who are abused. She proceeded to tell me about her mother, 90 years old, who had browbeat and abused her children and grandchildren, lied about them. She cheated them.

So, it happens at all ages, and I don't think people are being abused because they are elderly usually It is because of a family situation perhaps that existed before they were elderly. But even though these problems are not just unique with the elderly, it is hard to handle problems of this magnitude unless we zero in on some groups of people. Zeroing in on the elderly constantly, and by serving on important committees such as this one, which has done a great deal of valuable work that I am aware of, when younger people—and I see many young people here today—are interested in the elderly, and if we can reach them through the Congress, through the press, and acquaint them with these problems, it will help.

Mr. BONER. Any questions from the audience?

If not, Bill, thank you for taking your time to come and be with us.

Our next panel is going to consist of three people. Our first panelist will be Mrs. Marilyn Whalen of the Tennessee Department of Human Services, Division of Adult Protective Services.

Second will be Ms. Jackie Beery-Day of legal services.

Third will be Tom Read, district manager for the Social Security Administration.

Mrs. Whalen is program manager of adult protective services with the Tennessee Department of Human Services. She has had 7 years' experience in program development for the Adult Protective Services Program. She also serves on several committees advocating social welfare for the elderly. She holds a master of science in social work from the University of Tennessee. Also, Mrs. Whalen was very instrumental in assisting me with obtaining witnesses and information needed for this hearing.

Mrs. Whalen, we thank you for being here today.

Next is Ms. Jackie Beery-Day who is a paralegal/advocate with legal services of middle Tennessee since 1982. She is an advocate for the rights of the elderly and handicapped.

Ms. Beery-Day, thank you very much for all the help and effort you have put into this hearing. You have done everything possible to assist us in putting on this hearing, and I very much appreciate it.

Our third panelist, last but not least, all of us know because of his seniority in this position, if no other reason, is Tom Read, who is a personal friend as well as an outstanding citizen in our com-

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munity, and is our district manager with the Social Security Administration.

Tom is a very important member of this community, having served as district manager in Nashville since 1973, a career employee of SSA since 1958, serving in all field positions. He is a graduate of Marshall University in Huntington, WV, and has done graduate work at West Virginia University. Tom, I thank you for being here, as well.

I will let each one of you make your presentation, and after all three have concluded their presentation we will open the floor for questions.

PANEL 3, CONSISTING OF MARILYN WHALEN, PROGRAM MANAGER, ADULT PROTECTIVE SERVICES, TENNESSEE STATE DEPARTMENT OF HUMAN SERVICES; JACKIE BEERY-DAY, PARALEGAL/ADVOCATE, LEGAL SERVICES OF MIDDLE TENNESSEE; AND THOMAS L. READ, DISTRICT MANAGER, SOCIAL SECURITY ADMINISTRATION, NASHVILLE, TN

STATEMENT OF MARILYN WHALEN

Mrs. WHALEN. I appreciate the chance to speak to you today, and I will try to touch on four different areas and talk about the law in Tennessee, the need for protective services, who is currently receiving those services in Tennessee, and my recommendation for Federal action.

The Tennessee Department of Human Services is the agency which is mandated to receive and investigate reports of abuse, negligence, and exploitation of adults. We are also mandated to provide protective services when the investigation indicates that those services are needed.

The first law was passed in 1974, and that law mandated services to those 60 years of age and older. In 1978, a second law was passed that mandated protective services for mentally and physically dysfunctional adults of all ages. Then, in 1980, the provisions of the two laws were merged, and we are currently working under the Tennessee Adult Protection Act.

Our law is fairly comprehensive, and I will list a few of the provisions that it includes, one of those being that it has a mandatory reporting requirement for any person who has reason to believe that an adult is being abused, neglected or exploited, it provides for maintaining confidentiality of the identity of the reporter. It provides immunity for reporters from civil or criminal liability, provides for emergency court intervention, as well as some other legal options, including search warrants, injunctions and the ability to get court orders to provide in-home services or to consent to medical care or, when needed, to consent to placements.

Also, the law covers adults in any living arrangement so that we can offer services to adults who are in their own homes, or in the homes of others, as well as in institutional settings.

We know that there is a tremendous unmet need for protective services in this State. We are currently receiving approximately 350 referrals each month. We have an active caseload of around 2,700 cases, and about 70 percent of those involve adults who are 60 years of age or older.

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If we used the 4-percent figure published in 1981 by the Select Committee on Aging, we would estimate that approximately 33,000 elderly Tennesseeans need protective services. Currently, approximately 1,800 are receiving those services.

In 1984, the Department of Human Services conducted two special projects. The purpose of the projects was to try to determine what kind of increase in referrals we would experience in a planned community. A public awareness campaign was carried out. We did this in a very rural county in the State and in a neighborhood in one of the metropolitan areas.

After a 12-month period in the county, the rural county of the State, their referrals for that 12 months was 99 referrals, few referrals. The previous year, they had had 17 referrals. So that was almost a 500-percent increase in the adults that were referred to us.

In the neighborhood that was used in one of the metropolitan areas for an 8-month period, they had 11 referrals. The previous or comparable 9-month period, they had had one referral for that area.

This gave evidence to support the belief that we have, and many people at the national level have, that there are many adults being abused, neglected, and exploited, who are not receiving services, and without additional resources there is no way that we can currently meet the need that exists.

Additionally, at a time when we need to see a great deal of growth in this area, we could potentially be facing cuts, as the primary funding source for adult protective services is the Social Services block grant, which of course is the target of the Gramm-Rudman Act.

Out of those adults currently receiving services, I have a few statistics and a general description. We have adults ranging in age from 18 to over 100 years of age. Many are dependent on SSI and usually incapable of increasing their income. Sixty-eight percent live on less than $400 a month. Thirty-seven percent, when they are referred to us, are living alone; and frequently when they are not alone, another person in the household, that other person may need services, as well, and I am talking about elderly couples maybe in their seventies, eighties, nineties, that have grown too frail to care for themselves or for each other, or those elderly adults who have been left in the care of adult children, when those children are not capable of providing care for their elderly parents.

Many times the—and this has been brought out earlier—many times those adult children have problems that they are dealing with, as well—alcoholism or dependency, a great deal of stress, or other responsibilities that they are trying to handle. Sometimes the adult child is elderly themselves. You could easily have someone in their late eighties with someone in their sixties trying to care for them.

Many have limited support systems in that their family or friends are far away, or incapable of taking care of the problems which they are trying to deal with.

When referred to us, 47 percent are living with relatives when the referral is made. Ten percent of our referrals involve physical abuse of the adult. When we tried to determine what are some of

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the pressing needs, we found in 35 percent of the cases the need was identified as being one for counseling or casework with the adult and their family; 32 percent needed in-home services, homemaker services or home-delivered meals.

Most of the adults we worked with want to remain in their own homes and want to be as independent for as long as possible, and all of the adults which we work with need our help to protect themselves from abuse, negligence or exploitation.

The recommendation that I would have at the Federal level is that I believe the Federal Government needs to assume a strong leadership role in the development of an adequate system of protection for one of our Nation's most vulnerable groups, a role which is appropriate, and without which States will grapple individually and piecemeal with a very complex national problem.

The idea that I would like to see supported is not new, and that is that there is a real need for a national center to focus attention on the protective service needs of adults. I would recommend that this center—I would want it to represent adults of all ages, not only the elderly. There are some common problems. Things are very fragmented now. In an effort to try to provide adequate protective services we need a national focus and a national center on adult abuse and neglect.

We would like for this center to serve in several different ways: one, to collect and disseminate state of the art information on the prevention and treatment of abuse, neglect and exploitation of physically or mentally impaired or elderly adults; to provide funds for research and demonstration projects; develop and distribute public awareness information and outreach materials; to develop training materials for staff who are involved in the delivery of protective services; deferral materials to be disseminated to professionals to aid in the identification and treatment of abuse and neglect cases; and to provide grants to States who wish to develop, expand or improve the quality of services to these victims.

Such a center would increase the body of knowledge needed to develop the best possible services for adult victims, while also enabling States to benefit from the knowledge that other States have, sort of a clearinghouse, a way to share information across States.

One of our Nation's most vulnerable populations is currently paying a painful price for the existing fragmentation and lack of national commitment to attack this problem with the energy needed to make a difference. This is a problem in which the victims are almost always unable to organize and speak out for themselves due to their frailty, their feelings of shame, and their fear.

They are dependent on all of us to develop necessary programs and legislation which will provide at least a minimum level of safety and care for this group of citizens.

I think it is also important for people to realize that this issue has the potential of impacting on each one of us and our families. No one is immune from the possibility of becoming a victim.

Thank you.

[The prepared statement of Mrs. Whalen follows:]

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PREPARED STATEMENT OF MARILYN WHALEN

Tennessee Law

The Tennessee Department of Human Services is the agency in Tennessee mandated by state law to receive and investigate reports of abuse, neglect or exploitation of adults and to provide protective services when indicated by the investigation. Tennessee passed its first protective services law in 1974. The original law mandated the provision of protective services to elderly adults. In 1978 a second law was passed which mandated the provision of protective services for physically or mentally dysfunctional adults of all ages.

The provisions of the two laws were merged in 1980. The Tennessee Adult Protection Act currently includes such provisions as:

- mandatory reporting by any person
- confidentiality of identity of reporters
- immunity for reporters from civil or criminal liability
- emergency court intervention
- legal options:
  search warrants
  injunctions
  court orders to consent to medical care, placements, or in-home services
- protection for adults in any living arrangement

Need for Protective Services

Our department receives approximately 350 referrals each month and has an active caseload of approximately 2700 cases. Approximately 70% of the referrals we receive involve adults, age 60 or above. However, we know there are many adults not receiving the protective services they need. Using the 4% figure published by the Select Committee on Aging in 1981, we could estimate that approximately 33,000 elderly Tennesseans may need protective services, while services are presently being provided to only approximately 1900.

In 1984 the Tennessee Department of Human Services conducted two special Adult Protective Services projects. The purpose of these projects was to determine the increase in Adult Protective Service referrals when a planned public awareness campaign was carried out in a rural county of the state and in a specific neighborhood within a metropolitan area. Due to the need to maintain well defined boundaries for the two project areas, broad media coverage was not used. In Henderson County the referral rate for a 12 month project was 99 referrals compared to 17 the previous 12 months (482% increase). In the Parkridge area of Knoxville the referral rate for a 9 month project was 11 referrals compared to 1 referral for a comparable 9 month period. These projects have added evidence to support our belief that there are many abused, neglected and/or exploited adults who are not being reported to the Tennessee Department of Human Services and are not receiving the services they need. Without additional resources we cannot meet the need which currently exists. Therefore, at a time when growth is needed, Adult Protective Services could potentially be facing cuts as primary funding is from the Social Services Block Grant which is a target of the Gramm-Rudman Act.

Adults Currently Receiving Services

Protective Service clients range in age from 18 to over 100 years.

Many are dependent on SSI for their income and they are usually incapable of increasing their income.

Many live alone. When the household consists of more than one person, the second person is often also in need of services. Such as couples in their 70's, 80's and 90's who have grown too feeble to care for each other or elderly parents left in the care of dependent, limited or troubled adult children.

Many have limited support systems. Family or friends are too far away, have other responsibilities, limited income, may be ignorant, indifferent, resentful or simply incapable.

Most want to remain in their own homes and remain independent as long as possible.

"All" can no longer protect themselves from the abuse or neglect they suffer without our help.

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TENNESSEE
ADULT PROTECTIVE SERVICES STATISTICS
1985

The Adult Protective Services program gathers data on cases closed during the first month of each quarter. The following data was obtained from the questionnaires completed during Fiscal Year 1984-85.

Total cases sampled: 1472

1. Age of adult when referral was made:

18-39	12%
40-59	15%
60-79	47%
80 or above	26%

2. Reports were primarily based on:

Self-neglect	60%
Neglect by others	19%
Physical abuse	10%
Financial exploitation	4%

3. When the referral was made to the Tennessee Department of Human Services the adult was living:

With relative	47%
Alone	37%
With non-relative	8%
Boarding, group of foster home	4%
Hospital	2%

4. The referral was made by:

Staff of other social agency	20%
Relative	17%
Neighbor	11%
Hospital social worker	10%
Friend	8%
Doctor/Nurse	7%
Self	6%
T.D.H.S. staff	5%
Anonymous	4%

5. In valid cases the perpetrator was:

Self-neglect, no perpetrator	70%
Son	5%
Daughter	4%
Spouse	4%
Non-relative	4%
Parent	2%
Neice/Nephew	2%
Grandchild(ren)	1%
Brother/Sister-in-law	1%
Brother/Sister	1%
Facility/Institution staff	1%

6. In cases needing protective services the need was for:

Counseling/casework with adult or family	35%
In-home services (homemaker, meals, etc.)	32%
Nursing home care	18%
Mental health evaluation, treatment or placement	13%
Alternate/better housing	13%
Boarding, group or foster home	9%
Hospitalization	9%
Transportation	8%

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7. Income of each adult client

$400 or less per month	68%
$401 to $500 per month	10%
More than $500 per month	10%
No income, supported by others	5%
No income, no support	4%

Recommendations for Federal Action

I would strongly urge the Federal Government to assume a leadership role in the development of an adequate system of protection for one of our nation's most vulnerable groups. A role which is appropriate and without which states will grapple individually and piecemeal with a very complex national problem, the abuse, neglect and exploitation of physically and/or mentally impaired adults and impaired elderly adults.

The idea regarding the role which should be taken is not new, the need for a national center is evident to those of us working in this area. I would, however, recommend that the center focus on protective service needs of adults of all ages needing protection due to their inability to adequately protect themselves. This would be a continuation of the recognition of this broad based need as addressed by the service definitions of Title XX of the Social Security Act in the mid 70's.

Establish "National Center on Adult Abuse and Neglect" to:

- Collect and disseminate state of the art information on the prevention and treatment of abuse, neglect and exploitation of physically or mentally impaired or elderly adults
- Provide funds for research and for demonstration projects
- Develop and distribute public awareness/education and outreach materials
- Develop training materials for staff involved in the delivery of protective services
- Develop materials to be disseminated to professionals to aid in the identification and treatment of abuse/neglect cases
- Provide grants to states who wish to develop, expand or improve the quality of services to these victims

Such a center would increase the body of knowledge needed to develop the best possible services for adult victims, while also enabling states to benefit from the knowledge and work of other states. One of our nation's most vulnerable populations currently pay a painful price for the existing fragmentation and lack of national commitment to attack this problem with the fervor needed to make a difference.

This is a problem in which the victims are almost always unable to organize and speak out for themselves due to their frailty, feelings of shame or fear. They are dependent on all of us to develop necessary programs and laws which will guarantee at least a minimal level of safety and care for this special group of citizens.

This issue has the potential of impacting on each of us or our families. "No one" is immune from the possibility of becoming such a victim.

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STATEMENT OF JACKIE BERRY-DAY

Ms. BEERY-DAY. I am very pleased to be here. I did submit a prepared statement which includes some of my personal experiences dealing with problems of the elderly that have been exploited and neglected and physically abused.

It is interesting, sitting here between these people who represent the two agencies that I do battle with the most and provide me with the most referrals, so it is sort of, it is a very interesting panel here.

I guess my first thing that I want to say is, first of all, I am an advocate which I think everybody, every person in our society has the potential to be. I think that one of the major things that is missing cannot be fixed with Federal funds. It cannot be fixed with an appropriate comprehensive program that addresses the needs of the elderly. All of those things have to come together in a program that involves the community at large, the neighborhood, people's families, adult protective services, all the private agencies, the State and Federal funding.

Right now I believe through my experience, we do not have appropriate means to provide those services we prefer, we refer to, frequently to folks in need of them. People may not even know they are being exploited, OK. People may not even know that the person who is taking them to the store is taking some of their money. They may not know that they don't need 25 health insurance policies, but it is legal to sell it to them.

What I see is a lot of exploitation and a lot of neglect, and I think that our system is not set up at this point to respond well, even if it is required by law to report. The response is not sufficient if a person is neglected or if a person is exploited. The law does not outline well what can be done to assist that person, and I guess I need to understand better what does protective services mean, what does exploitation mean?

I was reading the Adult Protective Act, and exploitation is defined narrowly in terms of financial exploitation by family members or by somebody who is handling a Social Security check. I think that is extremely narrow.

Our folks out here are exploited by their family, not just financially but people lose their homes. They are exploited by door-to-door sales people, by people selling whatever comes up. It is amazing, and I think that we have to look at it in a much broader way than what we have.

The major response that I would like to see besides appropriate funding from the Federal Government is to use its ability to create public opinion, to use its leadership, to add value back into those folks that have put so much into this country and now want to live their lives out in some form of dignity, and to me we have devalued that population and the Federal Government, just how we now, people understand how important it is to have an appropriate national defense, people need to understand real leadership of the Federal Government. Through that leadership, it is important to protect those people and cherish those people that are so dear to our community. It is that simple.

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Mr. BONER. Thank you, Jackie. We have your prepared statement and appreciate your comments.

[The prepared statement of Jackie A. Beery-Day follows:]

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PREPARED STATEMENT OF JACKIE A. BEERY-DAY

Mr. Chairman, thank you for the opportunity to participate in this field hearing on the prevalence of elder abuse in this community.

As specialists in identifying problems (of) and providing services (to) our elders, it has been my experience that we continue as a society to underserve a large segement of the elderly population. Elder abuse is most likely to be identified in terms of physical, violent acts against the elderly. However, abuse includes neglect and exploitation as well as physical violence. Legal Services does see clients who are abused physically. The remedy, even through the courts, offers little support to the aging person experiencing violence in their home.

The majority of our clients are the poor or low income elderly. We see people that have suffered from serious neglect and exploitation. The exploitation usually comes from unscrupulous sales people, neighbors, friends, and/or family members. It is my opinion that the neglect stems from us (as a society) and in fact, our elderly poor are neglected by the system set up to serve them.

I believe if we as experts, identify the problems and identify the solutions and provide the services which bring support and relief to our elderly, then those services and the relief must be geared toward the specific needs of the elderly. It has been my experience that many of the specific needs are neglected. Perhaps it is because there is no agency which effectively looks at the elderly individual as a whole person consisting of problems which are inter-connected and cannot be solved in isolation of the other problems which exist. It seems that we have a relatively consistent means to deal with an immediate problem -- a crisis. Severely deteriorating mental capacity, for example. However, many times the person who is abused lives in a situation which foments violence, neglect, and exploitation because of limited income, limited contact with the outer world, limited medical followup and mental health counseling. We as doctors, legal representatives, social workers, van drivers, meals on wheels "deliverers", must be able

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to have a conscious means to identify unrelated problems which exist in the elderly person's life. A method by which those seemingly unrelated problems are corrected, is one that operates in the interest of the overall general welfare of the individual insttead of the present crisis-response model.

A client of ours, Mrs. "B" is an example. Mrs. B is an eighty-five year old woman who lives alone, has no family, and has lived in her present home for the past twenty years.

Mrs. B has osteoporosis and is permanently bent at the waist at a 45 degree angle. She has arthritis of her extremities and has lost all of her natural hair and teeth because of poor health and nutrition. Mrs. B has high blood pressure and takes medication for her heart. Mrs. B has a wonderful sense of humor and a rich history which includes growing up on a cotton plantation, many years of hard work and determination to make a life for herself here in Nashville.

Mrs. B was originally referred to Legal Services by a service provider who had had an open case on her for two years. I was informed by her "worker" that she had visited her on a relatively frequent basis. The referral came because Mrs. B had lost the deed to her house to a home improvement company, and Legal Services agreed to handle her case.

In the process of preparing for the case we identified the following conditions;

1) Six to eight unrelated people living in Ms. B's house. She did not know their names, we have not established whether they paid rent, they did not pay any electric, gas, or phone cost.

2) Electric, gas, phone service had been cut off on a regular basis because Ms. B could not pay the bills.

3) Stolen Social Security checks were common.

4) No food in Ms. B's possession, as she had no way of getting to the store on a regular basis.

5) The refrigerator was broken and in fact was inhabitated by nests of cockroaches and was a storage place for rotting food.

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6) Mrs. B had very poor medical care. She did not have a consistent treating physician. It was evident that her heart medication was two years old and that she was not receiving regular bathing. Her mental state was one of extreme disorientation.

7) Legal Services identified 20 health and life insurance policies which were sold Mrs. B by door-to-door salespeople. All were for a minimal amount. It was also discovered that the insurance agent would come to her door the day she received her Social Security check, cash it, and deduct his premiums. Mrs. B had no transportation to allow her to get to the bank, did not have direct deposit and this was the only way that she could get her checks cashed. Mrs. B receives both Medicare and Medicaid - she does not need health insurance.

8) Mrs. B was missing her savings account pasbook and she did not know where it was.

9) Her home was in serious disrepair and infested with cockroaches. The odor was almost unbearable, and the yard front and back littered with junk and garbage. The inside dirty and unkept. Mrs. B was a resolute that no one was going to "assist" her in moving to a high rise or a home for the aged or anywhere. She had worked all her life to buy her home and her furnishings and she had to stay and "take care of things".

After several visits with Mrs. B, she and I compiled a list of the most immediately correctable problems facing her.

Mrs. B needed: (1) financial services, someone to handle her money, pay her bills, or a limited conservator; (2) consistent and relevant medical services at at least weekly; (3) homemaker services, somebody to help her identify rotten food, help her clean her house, perhaps help her get to the grocery

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store; (4) companionship, that included someone going by to check on her, someone involved and interested in her problems, (perhaps living in her neighborhood or community); (5) transportation to the bank, the grocery store, to Dollar General, to the doctor, etc.; (6) home repair and maintenance - immediate plumbing needs, fumigation, minor repairs, help identify problems; help in calling plumbers, a carpenter, someone to fix a door, etc. (7) Legal advocacy and representation for her immediate legal problem; (8) hot meals daily, meals delivered to her, and access to fresh food to cook when she was inclined; (9) she needed some new appliances; a television set (for company), new refrigerator, working stove, etc.; (10) a person or agency available to coordinate and assure she received services as the need surfaced.

Out of the list, this community was able to provide very little. Ms. B received the legal relief, this included her tenants being asked to vacate the premises, her deed to her house, etc. She could get no financial services in this community unless she was declared incompetent and was appointed a conservator who would then pay her bills and charge her a fee. In the interim, on a volunteer basis, I pay her bills each month. She is not able to get a homemaker to help her around the house. Her name was submitted for consideration in March. In the interim, volunteers from Legal Services and friends have assisted in basic cleaning up of the inside and the exterior of her house. Transportation to the doctor has been available through her new health care provider. However, again, her specific need in terms of transportation is not addressed. She is slow, she does not hear too well, she needs reminding that she has an appointment. If the bus comes, blows its horn, or the driver even knocks on the door she may not hear it. If she does hear the door she is so slow getting there, the driver assumes she is not home and leaves. This has happened several times. The transportation is so scarce, that if she has a 2:00 o'clock appointment, she is picked up as early as 8:30 or 9:00 a.m. in the morning and will have to wait all day at the health care center. Transportation to the bank or shopping are

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provided on a volunteer basis by Legal Services staff.

Legal Services tried to get the church (to which Ms. B belongs) involved in helping fix up her yard and repairing a few broken doors, etc. We have had no response to my letter written directly to the minister. In relation to repairs and maintenance on a regular basis, there is nothing that exists in this community. We were told it would take several weeks for Mrs. B to receive meals delivered to her door. It took two and a half months before she began to receive food from the provider. In the interim, volunteers from Legal Services and the community provided daily hot meals for Ms. B. Since the agency only works Monday through Friday, Legal Services volunteers and friends are rotating weekends to take Mrs. B one hot meal for each of the two days on the weekend.

Ms. B deserves and needs a lot more ongoing follow up and direct intervention than our service providers are able to give her. She deserves a comprehensive problem solving approach to her situation before it becomes a crisis. She deserves to make the choice to stay in her home as long as she can function independently and we as a society owe her the protection of her rights as a citizen of the United States and as a member of our community to live with dignity in her own home. Ms. B, in my opinion, has been neglected by the system, has been neglected by her community, has been exploited by people whose income is generated by preying on confused elderly people.

A thoroughly cohesive, consistent, and action oriented model needs to be set up to deal with the problems that are facing the elderly in this community. Exploitation and neglect are more common than we want to see. Physical violence against the elderly is more common than we want to recognize. The crime is we serve our elderly citizens between nine to five Monday through Friday, with a "crisis management system." We must find a way to organize our communities, to educate our neighbors, to provide good comprehensive and cohesive holistic responses to the problems of the elderly.

How Can The Federal Government Respond To The Problems Of Physical Abuse, Neglect and Exploitation Of Our Elderly?

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1. Funding for human needs should be a priority of our federal government. A service delivery system that provides a comprehensive, all rounded, holistic approach to services for our frail elderly, should be appropriately and adequately funded by the federal government. In other words, the idea that protective services consists of crisis response, subsistence existence and shelter is not sufficient. Protective services should include such things as; regular homemaker services, regular meals, regular medical care, community involvement, and swift legal response to those who abuse/exploit and neglect the elderly.

2. The federal government, through its leadership, should promote the value of our elderly persons as a matter of American pride and patriotic duty. As we now promote the value a national defense system, we should also promote our elderly as one of America's cherished resources.

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Mr. BONER. Tom Read.

STATEMENT OF THOMAS L. READ

Mr. READ. Thank you, Mr. Chairman.

Abuse of the elderly in regards to Social Security involvement does not address physical abuse. The abuse we see pertains primarily to abuse of the elderly's money—the monthly check that the individual receives from Social Security.

This abuse occurs more frequently in situations where the older individual receives his Social Security check in his own name and someone closely associated with the individual takes the check, cashes it over the elderly individual's signature and then uses the money in part or fully for their own personal benefit, rather than the elderly individual's use.

The second situation involves an elderly individual who is either incapable or incompetent to handle his own funds. Social Security establishes, with the support of a medical statement of a physician who has examined the Social Security beneficiary within the last 12 months, a representative payee to handle the elderly individual's Social Security funds.

The representative payee is legally authorized to cash the incapable individual's check and is required to use all of the Social Security payments for the benefit of the incapable person.

Social security annually checks with the representative payee for an accounting of the funds of the incapable individual. The representative payee is required to complete a form which asks for an accounting of the disbursement of the funds he has received throughout the last 12-month period on behalf of the incapable individual. If the response from the representative payee is acceptable and reasonable, no further review is made. If not, then a more intense review of funds disbursement is done. This usually involves a face-to-face interview with the representative payee and further accounting of funds.

The above procedure tends to limit but by no means always ensures proper use and disbursement of the elderly individual's social security funds.

If abuse of the money is established, the representative payee is requested to make restitution of the improperly used funds. If the request is ignored and circumstance in the individual case warrants, the file is sent to the U.S. attorney for his consideration of criminal prosecution. Once the case has been referred to the U.S. attorney, Social Security does not retain jurisdiction of the file.

Abuse to the elderly also presents another area of consideration for Social Security that I feel merits your awareness.

This area relates to services that Social Security provides. There are five major programs which Social Security administers: One, retirement; two, survivors; three, disability; four, Medicare eligibility; and, five, Supplemental Social Security Income benefits.

Four of these five programs relate in full or in part to aged individuals.

The retirement program provides benefits at age 62 for individuals desiring to retire early at a reduced benefit rate and at age 65 at the full benefit amount.

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The survivors program makes possible widow and widower's benefits again at a reduced rate as early as age 60. The full rate is made to those widow and widowers desiring to wait until age 65.

While individuals frequently think of Medicare being available only to individuals age 65 and older, which is in fact the largest group of users, Medicare is also available to those individuals under age 65 who have been eligible for disability benefits for 24 months. Their Medicare coverage starts with the 25th month. The third group is those individuals who suffer with chronic renal disease.

The Supplemental Social Security Income Program provides assistance to three categories of individuals who also meet an income and resource requirement: one, individuals age 65 and over; two, totally disabled; or, three, blind individuals.

To provide these services, there are 30 Social Security offices in the State of Tennessee. To assist in the taking and development of claims for monthly payments of Social Security benefits, five of these offices service the 15 counties in the immediate middle-Tennessee area, two here in Nashville, one each in Clarksville, Gallatin, and Murfreesboro.

Individuals desiring services can transact most of their business by phone, mail or by coming into the Social Security office nearest to them. We also provide regularly scheduled contact station services in every large community that does not have a Social Security office located there.

This concludes my summary of the Social Security Administration involvement in providing services to the elderly and our efforts to prevent abuse through mishandling of Social Security payments to a representative payee on behalf of an incapable individual.

I want to thank the members of this subcommittee for providing me the opportunity to appear here today.

If I may be of further assistance, please let me know.

I have listened to a lot of testimony this morning, and it is very difficult to put your finger on the kind of situation that brings attention to the services that you need.

I heard some criticism of various departments and agencies, and that well could take place with us, with some of the reports that we receive. There are an awful lot of people out there, and to try to maintain some kind of control or policing action over their type of referral is virtually impossible.

With the Gramm-Rudman, a lot of the other budget cutting acts which are necessary, these kinds of situations are going to increase. What I am concerned about, from my perspective in Social Security, is the fact that the public is aware of what is occurring to an elderly individual not just the elderly. We also have people that are other than aged that are abused.

Whatever the circumstances, involving Social Security benefits misappropriated, I would certainly appreciate if the individual who is aware of it would contact any of these Social Security offices across the State, make us aware so we can investigate, and we will. We may not be as fast as some people would like, but we do investigate these things and try to do the best we can. We need to be aware of them. That is my recommendation, public awareness.

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Thank you, Mr. Chairman.

Mr. BONER. Any questions?

MEMBER OF THE AUDIENCE. Why is it so hard, Mr. Read, for a person my age to get this disability? Why do you have to wait until you are dying to get it?

Mr. READ. Hopefully, you don't have to wait until you die. I think we have had abuse of the program, where people have established disability and at one point or another have recovered and have failed to report that fact to us, and we are not aware of it, and consequently in reviewing and looking at the program, the disability program, it becomes necessary to tighten up the requirements and the regulations.

The intent of the law was to provide disability payments for the individual who is totally disabled and expected to remain that way for 12 months. We find a lot of the individuals are not able to work in whatever job they have held in the past, or the areas that they have been trained, but they are able to do other types of work. The fact that that work is not available does not preclude us from finding that the individual is able to be engaged in a type of work, whether it is there or not is immaterial.

We find situations where the person can't go out and do physical labor, but he could do some other types of work. The fact that there is no work there doesn't change the definition that he is able to engage on a limited basis in substantial work, the individual is not fully disabled. You have got to be 100-percent disabled at the time.

Mr. BONER. Let me respond to part of that, because, Tom, in his role and others on his level do not formulate the policy. This policy is formulated out of Washington.

There were complaints by administrative law judges, there were others, that out of Washington, once again, as far as what the doctors say, administrative law judges, what they approved, it is not in its purview for that decision to be made, but there were, I think, to be charitable to all individuals, there was clear evidence that in some areas quotas were being placed on doctors and law judges as to the disability number, the number of disability cases that were allowed to be granted.

In Congress, we passed legislation to alter that policy. We also passed legislation—before what they would do is they would send the notice and say you were cutoff. Then you had to assume the position of guilt and had to prove your innocence, in that you had to go back and prove again why you were still disabled; and in the process of that, your benefits were cutoff, and there were a number of people across this country, as we had hearings on this in Washington, who simply did not have the money to seek legal counsel to have their position heard before the proper agencies and presented in a proper way.

As a result of that, we passed laws in Congress that said that if an individual is going to be reevaluated, that you cannot cutoff their benefits until they have gone through that process, as has been determined. This happens at the great mecca, and not out in the field, and I have said many times if some of those folks in D.C. would get out in the field, they would become a little more realistic about what is taking place, but it is very difficult, and there are

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people who have abused the system and those of us in Congress try to pass legislation to give the intent and the direction of that policy, and sometimes it has been misinterpreted, and the misinterpretation of that policy is then required to be carried out across this country.

And the hearings we had on a situation similar to this have proved to be very beneficial and help to bring things in a better perspective.

Mr. READ. Another thing you need to consider, in relationship to your question, particularly in relationship to individuals trying to establish a period of disability for the first time. This program is what I call a gray area program. By that, I mean this, what is disabling to one individual is not disabling to another, and then we tell the story about an attorney, as an example, a person who performs manual labor, both lose their legs in a terrible accident. The attorney is not found disabled because he can still go ahead and practice his business without the use of his leg; and yet the bricklayer, this is the only means which he has of providing his livelihood, and with the loss of those legs, he can't be retrained to do anything else because of the limitation factor, and you would find him disabled.

Here you have two individuals, both with the same impairment because of the residual capacity, or training of these people, one is disabled and one is not. You have to have your disability established based upon the support of medical evidence, and those tests are not always clear, concise, so you can draw a line and say this person over here is disabled, and this person is not. It is a judgmental area.

Physically or mentally they may not be totally disabled. It is a very, very difficult program to administer, and there are cases on both sides where the individual should not have gotten the benefits, but for whatever reason did, and the very deserving person, on the other side, did.

Mr. BONER. Seventy-three percent of the referrals you receive are elderly, and the vast majority of these people suffer from self-neglect, and is this due to mental decline or can we educate older Americans to better care for themselves? Mrs. Whalen.

Mrs. WHALEN. The self-neglect cases we serve could be due to mental decline or physical. Basically we are talking about those adults who are not able to take care of their basic needs, and it could be mental or physical.

I suppose there is the possibility that taking care of yourself early on could help ward off some of those problems, but I don't think that all of the conditions that we find are necessarily things that people could prevent. An example of that may be Alzheimer's, trying to provide services to those adults who develop some disease that they probably were not able to prevent in earlier time.

Mr. BONER. Any other questions anyone would like to ask? OK.

MEMBER OF THE AUDIENCE. You mentioned on the investigations that the agency has designated payees or representative payees. How many of those cases do you have in the State, and how many are referred to the Justice Department for investigation?

Mr. READ. I have no idea. I don't have privy to that information except on a statewide basis. We have 543 representative payee re-

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quests pending right now, and the last figure I saw was last week, 30 of those are under current investigation beyond the routine response. We get these responses in weekly from our program center, so this number varies drastically.

Mr. BONER. Any other questions?

MEMBER OF THE AUDIENCE. I would like to ask a question. You point out that we have a situation where these individuals, theoretically at least, are employable but the mechanism does not exist for them to network and share their labor experiences. Former Secretary of HEW, Wilbur Cohn, said we in America, if we are going to go the route we are going now, we hope to create an Americanized version of a mini-Kibbutz and train people with varying degrees of capacity to support each other and to run that sort of mechanism, you can't run it on totally volunteers, you are going to have a small staff somewhere. That unity is missing in that system.

How do we get the opportunity to help people help themselves, instead of sitting and stewing and getting very angry at you for situations that are above and beyond the jurisdiction of the law, as it now applies to many, many people?

The high risk people in this town, and there are 40 major community centers where elderly populations are concentrated, and they are getting an increasing number of people who have great difficulty in living independently. Yet the mechanism for training some of the people within the same housing, elderly housing, doesn't exist, and the administrative mechanism for cooling the capacities and doing, if nothing else, a co-op skill bank to share doesn't exist; yet with rare exceptions I happen to be running one that has trained about 600 people, and 60 of them very specifically, and Gramm-Rudman has wiped us, but we are going to keep it running anyway.

Sometimes the way the system works is to wait until it is an absolute crisis and then spend 10 times what it would have taken to keep that person out of an institution for the next 5 years.

Mr. BONER. Any comments?

MEMBER OF THE AUDIENCE. When are you going to bring utopia down here? I know Tom Read is supposed to be able to walk on water. When are we going to be able to get the public and private resources together to do some of the things we discussed here today?

Mr. BONER. One of the advantages of this and one of the purposes of this is to try to highlight the problems of elderly abuse, and I hope we have accomplished some of that today.

Any other questions before we close?

I want to thank all of those who have participated on the panel for working with us and allowing us to put this together, for you to be here, and especially the staff from Washington to come down and be with us. I will now declare the meeting of the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging closed.

[Whereupon, at 11:30 a.m., the hearing was adjourned, subject to the call of the Chair.]

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APPENDIX

Statement of

KENNETH M. MATHEWS JR., MD., M.S.P.H.

Assistant Professor of Medicine

Quillen - Dishner College of Medicine
Johnson City, Tennessee

Thank you for the opportunity to participate in this hearing on the Issue of Elder Abuse.

I. Prevalence Issues.

Elder Abuse is the social issue of the eighties. Child and Spouse Abuse have had their emphasis and are certainly still a problem. But, with the Graying of America, there is urgent need of raising the social consciousness of the citizenry on this subject. I would urge that when we define Elder Abuse we think of neglect, isolation, psychological abuse and financial exploitation. Physical abuse occurs the least often of these categories though it is certainly serious when it occurs. However, we must think in broader definitional terms nationally than just physical abuse.

No new major prevalence studies have been reported since the initial ones in the late seventies and early 1980. The studies of Hickey and Douglas in Michigan, O'Malley in Maryland and a few smaller case control studies form the basis of the statistics that we quote on prevalence. Some State Human Service agencies have undertaken limited surveys of the Adult Protective Services cases on Elder Abuse, but these are not full surveys accomplished over a full year's time. These non-randomized samplings do not fully reflect the true prevalence of Elder Abuse.

Regarding the experience of Tennessee, I expect other testimony from Human Services to report more specifically on pilot studies done in two counties to see if people would report more suspect cases to the agency. This data will show that large increases (up to ten fold increase in one year) in reporting of suspected Elder Abuse occurred. The biggest problem with encouraging increased reporting is that State Agencies do not have enough personnel to deal with the regular Adult Protective Service case loads, let alone encourage the reporting of more suspect cases of Elder Abuse.

II. Support Service Issues

It should be noted that the backbone of support for Elder Abuse victims in the pwblic sector is the Adult Protective Services case worker (APS) from Human Services.

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Our observation has shown that the neighbors, law enforcement, relatives and friends rely on the case worker to propose and dispose in the care of the victim.

Case workers have more responsibilities in the Human Services offices than just dealing with Elder Abuse. Depending on the size of the agency and number of workers they may care for the entire range of human services clients. Larger metropolitan areas may have full time APS workers but they handle all adult age groups, not just the sixty-five and over group. People trained to recognize and deal with Elder Abuse are therefore few in number.

Case workers attempt to solve many of the Elder Abuse Cases with community services ranging from family, friends, Mental Health, Public Health, Aging Agencies, Human Services, Churches, etc. Unfortunately, many of these public assistance agencies are experiencing economic cutbacks and reduction in services. CHORE, Homemaker, SEND, Meals on Wheels, come to mind. These were most beneficial in maintaining the elderly's independence, but not nearly adequate to handle the demand when funds were plentiful. Now, with the funding cutbacks these services are being reduced even while the demand moves higher. This leaves less support services available for the case workers' use.

III. Miscellaneous Issues of Importance

A. One risk factor that appears to be very important in Elder Abuse is the issue of Dependency - Counterdependency. Several case control studies in the last three years have illuminated the fact that how dependent the care-giver is on the victim and vice-versa appears to determine how likely abuse of some type is to occur. Any efforts directed at solving the problem of all types of elder abuse will have to find ways to reduce the friction that dependency-counterdependency brings on the relationship of the care-giver and victim.

B. Projects already formulated and in some instances in the implementation stages are temporary shelters for abused Elderly and Day Care for the Elderly. These have seen very limited trials in Tennessee and have been successful but without funding, have no chance of spreading outward from the metropolitan areas into the rural communities.

Conclusions

A. Elder Abuse of all types is under reported. Case workers are already over burdened with work. Attempts to encourage more reporting will probably flood the system with more cases than manpower exists to cope with them.

B. The well known support services that aid the case workers in solving Elder Abuse problems in the Community must be expanded not reduced. They must be expanded into the rural areas. CHORE, SEND, Foster Grandparents, Meals on Wheels, etc.

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IV. What Federal Response is necessary?

A. It is easy to say more funding is necessary for complete resolution of the problem. Undoubtedly, further federal financial support will be needed, but fiscal constraints limit the amount of real dollars that will be allocated.

B. The passage of a Federal Law on Elder Abuse is overdue. This would do so much to standardize nationwide efforts and help to raise social consciousness.

C. Following passage of a law - The fifty states should be asked to report on all cases of suspected Elder Abuse from their Adult Protective Service Divisions. This reporting must be standardized.

D. Community Support Service Agencies need financial support to gear up for additional delivery of services to the Elderly. They should be available for support of the APS workers in dealing with Elder Abuse - urban and rural.

E. Shelter Homes and Day Care Concepts should be expanded and developed as an additional aid in working with Elder Abuse victims and care-givers.

F. Mechanisms of relief for the care-giver especially the involuntary care-giver must be explored to reduce the tension brought about by dependency-counterdependency.

Many details of these concepts obviously remain to be worked out. This hearing at this juncture is primarily interested in focusing the problems and proposing a larger design for solution. While many states including Tennessee, have enacted laws concerning Elder Abuse, there needs to be a master plan and national direction on the issue. These hearings will greatly contribute to this objective.

Thank you for allowing me this opportunity.

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STATEMENT OF DIANE STEPHENS, ROCHELLE CENTER,

NASHVILLE, TN

Mr. Chairman,

I appreciate this opportunity to submit testimony for the congressional record on behalf of the neglected elderly parents of mentally retarded adults. As Director of Family Services of a sheltered workshop and training center for mentally retarded adults in Nashville, I have known cases of abuse and neglect against the mothers and fathers of retarded adult children due to a variety of reasons.

These parents have been virtually ignored by society for the painstaking responsibility of caring for and supporting their handicapped children. They have nurtured their sons and daughters into adulthood without the hope of planning a life of independence and freedom. These senior citizens, especially the widows, are being forced through the lack of community services to endure a lifetime of parenting at an age when capabilities often decline.

At our agency alone, 24% of the parent population is between the ages of 65 and 92 with their handicapped children ranging from ages 24 to 65. These figures will double by the year 2000. With the result of de-institutionalization, state government has left the burden of care to single elderly parents who are physically and often mentally unable to continue the awesome task of caring for a handicapped adult.

We have known cases of frail elderly widows who have been physically abused by their mentally retarded sons or daughters. Some who actually fear them, but have no alternatives available in terms of residential placement. Many times the poor elderly find it necessary to depend on their child's disability check for their own survival. We continue to see the needs of these elderly single parents being displaced by the economic priorities of the system itself.

And what about the future of the elderly poor who are mentally retarded? Without secure placement plans, they will be left to fend for themselves in the streets when their parents die. Without a network of community services supported by local, state and federal government these mentally handicapped adults will be at the mercy of opportunists and criminal elements taking advantage of their benefit payments. We have seen the retarded being robbed and prostituted when left alone. This exploitation will continue to increase as the aging population grows.

At this point in time the future appears dim. There has been little or no support for the single elderly parents of mentally retarded adults who never had the option of "letting go". Society prevented them from fulfilling a normal life. They became permanent parents without choice and now there is no one left to care for their needs. There must be supportive services available to assist them in daily living as well as to provide residential facilities for their handicapped adult children. Both elderly populations need the help of coordinated social services and community programs to enhance the lives of "America's cherished resources".

Thank you for your time and attention.

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Additional material submitted for the record, by Dr. Curtis B. Clark

Geriatric Medicine

Geriatric Abuse—Out of the Closet

CURTIS B. CLARK, M.D.

The purpose of this series of articles is to present geriatric abuse as we have finally accepted it—as a fact of life. In the first presentation its prevalence, proposed etiologic causes, and psychosocial sequela will be demonstrated. The second in the series will present the formation and utilization of a Geriatric Abuse Intervention Team (GAIT) in a Family Practice training setting, and in the third actual cases will be presented in which reasonable solutions have been brought about through the use of an interdisciplinary GAIT.

On April 21, 1980, a congressional hearing was held by the Subcommittee of Human Services concerning domestic violence against the elderly. During the opening of the hearing Ms. Geraldine A. Ferrara, who had served in the Assistant District Attorney's office in the Queens County District Attorney's office, and who had implemented the "battered spouse legislation" and prosecuted cases of child abuse while in that office, summarized the magnitude of the problem of geriatric abuse.[1] Her opening remarks are an accurate statement concerning this problem: "At the same time, I urge the Congress, the social service providers, and American families not to overlook this serious problem. Statistics indicate that domestic violence against senior citizens is occurring with alarming frequency and it is increasing. I am concerned that the failure to improve services for these victims will only increase our nursing home population and increase the numbers of senior citizens who are physically and mentally damaged."[1]

A study conducted by Legal Research and Services for the Elderly indicated that the typical victim of domestic geriatric violence was a frail 75-year-old woman; 84% of the abusers were relatives and 75% of the victims lived with their abusers.[1] A University of Maryland study concluded that domestic violence is more likely to occur among low and middle income families.[1]

Some 20 to 25 years ago our awareness of child abuse was brought to the forefront. Today we stand hopefully on the threshold of being alerted nationally to the scope of this problem. During the latter part of the 1970s the problem of geriatric abuse was uncovered by the pioneer work done by the University of Maryland and the University of Michigan. These studies indicated that like spouse battering and child abuse, elder abuse also occurred in families.[2]

Investigators have documented hundreds of horror stories of repeated physical battering, sexual abuse, intentional overmedication, psychological torment, financial exploitation, and forced confinement of the elderly by their own families. There have been many reports that elderly abuse is serious and growing, but because the thought is so repulsive, many refuse to accept this as a possibility, and the subject is ignored.[3] The incidence of geriatric abuse of some type or combinations of abuse occurs in approximately 10% of persons over 65 years of age. Data suggest that in America we have from one-half million to one million cases of abuse occurring each year.

Generally there are five types of accepted abuse in the elderly, which include physical abuse, including sexual abuse; passive neglect; active neglect; psychological or emotional abuse; and material or fiscal abuse. Passive neglect is demonstrated when an elderly person is not turned in bed, permitting decubitis ulcers to occur. Active neglect occurs when a patient has had certain needs or medications withheld that are needed for daily living.[4] Many of the abused elderly are like children—frail, dependent, and vulnerable. Admitting that they have been abused is to admit they have failed as parents.[2] It is difficult to admit even to themselves that their own offspring would commit such an act, much less admit that such had occurred to an outsider. The elderly are very reluctant to seek help, fearful

From the TMA Long Term Health Care Committee. Dr. Clark is with the Family Practice Center, Department of Family Practice, University of Tennessee Center for the Health Sciences, Jackson.

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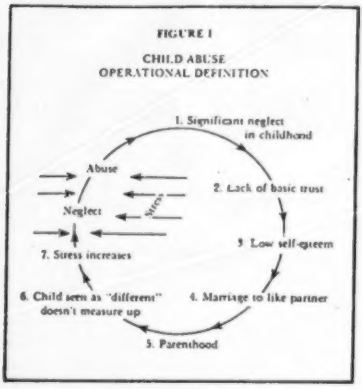

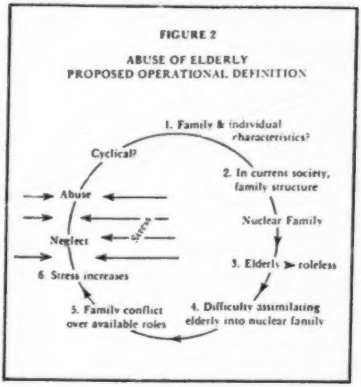

that will place them in greater jeopardy for more abuse. Many elderly have no place to go and fear leaving their home and security because they have no other alternative available.[3]

William Shakespeare wrote 475 years ago about the "King Lear syndrome," as we write about the "granny bashing" syndrome today. Shakespeare wrote about the same type of conditions that many of the grandparents are being subjected to today.[1] At present there is no proven operational definition for "geriabuse." There are four explanations given as to the operational or causative factors. There may be developmental disorders in the caretaker and vulnerability and dependency of the victim. There may also be situational crisis-induced factors or socio-environmental conditions.[4]

There is a generally accepted operational definition as it relates to child abuse (Fig. 1). During childhood there is neglect and inadequate parenting that will lead to lack of basic trust and low self-esteem. Later in life the person will enter into marriage of a like partner. When parenthood is achieved and the child is seen as "different" or doesn't measure up, this sets the stage for abuse. As stress increases then there is the breaking point at which the child is neglected and abused.[5]

There has been proposed what seems a very reasonable chain of events that brings about abuse of the geriatric patient (Fig. 2). The caretaker may have been abused as a child where violence and neglect was the normal mode of behavior. In our current society the elderly may have to be brought into the nuclear family that has evolved after the industrial revolution. The person may be looked upon as nonproductive and roleless, being a burden rather than a contributor. With this difficulty the parents have to give up their independence and conflict arises as the role reversal takes place. Then some psychosocial or economic stress occurs with neglect and abuse the final result.[5]

Eleven states have protective service laws that require anyone who suspects elderabuse to report such instance to an adult protective central office.[3] These hideous acts have obviously been with mankind throughout the ages and only within the past few years have we as a society begun to face the issue. It is mentioned in Ephesians 6:2, 3, and I quote: "Honour thy father and mother; (which is the first commandment with promise;) That it may be well with thee, and thou mayest live long on the earth."

Acknowledgment

Figures 1 and 2 are reproduced with permission from the *Journal of Gerontological Nursing*, copyright SLACK, Inc., July-August, 1979.

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Geriatric Medicine

Geriatric Abuse Intervention Team in a Family Practice Setting

CURTIS B. CLARK, M.D.

This second in a series of articles explaining and discussing geriatric abuse will deal with the formation of a Geriatric Abuse Intervention Team (GAIT) and the persons who compose it.

It had become apparent to us in our Family Practice program that many of our clients had few, if any, appropriate advocates. Though solutions could be obtained, they were very time-consuming, and delayed the much needed services to our clients. Our needs as we perceived them were threefold: to render service to our clients, to serve as role models to our residents, giving them an opportunity to be involved in the decision-making process, and thirdly, we felt that we could be a learning resource to our colleagues in the medical community and related professions as well as society.

We believe that to deal with the complex issues of the health care system, in order to be most effective the physician must work as a member of a health care team. In so doing we must be willing to broaden our own personal education as well as that of colleagues in all fields, of society, and of those who need the services of such a team.

Family physicians are trained to learn and understand families and their members well. This allows the family physician to understand the dynamics and social interactions so that he can better predict which families are at greater risk for abuse.

In 1978 a study conducted by Kosbery in Cleveland revealed about 10% of 404 clients over 60 years of age had been abused in some manner. It was apparent that some of these people had been beaten, starved, isolated, or neglected. Block believes that elder abuse is less frequent than spouse abuse but has about the same occurence rate as child abuse.[1]

The success of the GAIT lies in many factors. A number of interested, very capable caretakers felt the need to collaborate and coordinate their services in order to accomplish this one common goal. It meant a willingness to give up some of their individuality and share with other professionals some of their authority and decision-making to better serve a patient's needs.

The original team was composed of a family physician interested in total family care, but with a personal interest in the elderly as evidenced by his interest during medical school and over 25 years with a large complement of elderly patients in his clinic, hospital, and nursing home practice. Another member of the team was a clinical psychologist who has had many years of experience in dealing with families, their interactions and dynamics, and a special interest in the problems associated with aging. There were two residents on the team; they volunteered to add their energy and expertise in geriatrics and at the same time better learn to render service to those elders in their residency clientele and finally in their permanent practice sites.

There was a registered pharmacist who also was in charge of a regional quality assurance program with the Southwest Tennessee Regional Public Health Office. The services of the regional Department of Human Services director, who has worked in this area for many years, has made a significant contribution in the discovery of cases and coordination of data collection concerning the circumstances and needs of each client, as well as aiding in protection of the individual client's rights.

From the TMA Long Term Health Care Committee. Dr. Clark is with the Family Practice Center, Department of Family Practice, University of Tennessee Center for the Health Sciences, Jackson.

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Nurse clinicians who taught in our residency program served as advocates for the clients' personal, physical, and nursing needs, and brought a unique perspective of meeting human needs so often overlooked. To complete this team, a doctoral medical educator coordinated and evaluated the educational aspect, to meet the needs of the residency program and assist in the dissemination of the educational process to other health care professionals in the community and our medical schools.

One of the most significant facts concerning the dilemma of our senior citizens is how the elderly feel about their circumstances. The aged usually have positive feelings about their aging and dying. Obviously, they see youth as desirable, and tend occasionally to use denial against being old. The healthy old person seems not to experience our cultural stereotype of old age,[2] and it has generally been accepted that the severity of abuse is related to the amount and kinds of disability rather than age per se.

Though I have seen several definitions of abuse of the elderly, none has been more complete than the one given by Levine: "Abuse . . . is any action on the part of an elderly person's family (family being defined as any relatives related by blood, marriage or adoption, and any associated persons who have daily household contact, such as a housekeeper or roommate, or any person upon whom the elder is reliant for his daily needs of food, clothing, or shelter), or a professional caretaker to take advantage of his person, property, or emotional being through threat of violence, use of violence, or use of disciplinary restraints (i.e., physical and chemical straightjacketing) or negligence on the part of the caretaker to provide basic needs."[2] They designated persons over 60 as elderly in their article.

It seems to be generally accepted that the British have been on the forefront of geriatric care, and especially rehabilitation of the older person. Baker in England has coined the now accepted term "granny battering." He chose this term to bring attention to the reality "that old ladies might be ill-treated not only by short-tempered relatives, but also by well-meaning hospital staff."[2]

It has been estimated that 500,000 persons aged 65 or older who live with relatives are now being abused. Abuse of the elders is at the hands of relatives, neighbors, and friends. Abuse of these persons is multiple.[2]

In our work with our team we have seen abuse in many forms, including psychological, physical, financial, and general neglect, which is particularly difficult to detect and also difficult to evaluate. Even though we suspect that abuse has occurred, isolation of these persons and their mental status make documentation and evaluation very difficult when trying to find fair and appropriate disposition.

The first point is that we must make all persons aware and to personally, realistically face the simple fact that time will make each of us an older citizen. As long as we ignore that, our chance of success has been lessened. Only after education of the public, persons in government, and health care services, can we expect to remove this blight on our society and bring geriatric abuse out of the closet to its proper state of awareness.

GAIT may fail to function for several reasons. One problem has been that for so many years physicians have been the only persons to make decisions about patient care, because it is difficult for physicians and other health care professionals to share these responsibilities. The various disciplines may see a problem in a different light, making negotiations necessary before a final plan can be effected. It is also more time-consuming when meetings must take place before a final decision is reached, even though the decisions are generally more appropriate.

Power struggles within the team itself can be very destructive. To be able to function most successfully, each member must know and feel that the patient's needs can best be served by the interdisciplinary team approach.

We believe our experience has now been successful and has served our clients' best interests. We have been careful to see that emotionalism and sensational aspects have been left aside, and have tried to use the same logical steps and decisions that a physician would use in his approach to a medical problem. Our basic proposal is that in all communities such a team could be assembled from available interested and knowledgeable people. The necessary ingredients are caring about people, a basic knowledge of their needs, and a desire to respect and cooperate with all team members sharing equally in the decision-making—The Principles of Democracy.

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Geriatric Medicine

Successfully Resolved Geriatric Abuse Cases By the Geriatric Abuse Intervention Team

CURTIS B. CLARK, M.D.

This is the third article in a series relating to geriatric abuse. The incidence, etiology, the formation and utilization of an interdisciplinary Geriatric Abuse Intervention Team (GAIT) having been presented, we will now present case histories of cases in which a reasonable solution was achieved. The most desirable solution may not always be possible, but what we have tried to accomplish is the solution that will respect the individual's rights and still be morally, legally acceptable and will be the most humane.

The first case was that of a 67-year-old white widow who lived alone with her pet dog. Our first contact was made by the patient, her sister, and the Department of Human Services. Her living conditions were deplorable; the premises were soiled, and there was little or no food available. Even though her sister would occasionally bring her food, she would refuse to eat, apparently to irritate the sister. The patient was lethargic and slow to respond to questions; she wore a wig, and physical examination showed her to be very thin, pale, and very weak, with much loss of hair. Breath sounds were diminished over the right chest, with dullness to percussion. Her hemoglobin was 7.5 gm/dl, hematocrit 21%, and T_4 less than 1. Initial chest x-ray revealed a large mass, thought to be a malignancy. When discussing the need for hospital care, the patient agreed and stated, "I have gone as far as I can go." She cooperated until there was a need for invasive tests, which she refused. Almost daily her sister would agree to accept guardianship, but at the last minute would decline. At this point the indication from the hospital was to discharge the patient, but this did not seem appropriate. The GAIT was consulted, and the decision was made to go to court, which granted custody to the Department of Human Services. When the patient alleged that a family member had $1,200 of her money, investigation showed this to be correct, and the money was turned over to an appropriate person.

Further tests revealed that not only did the patient suffer from anemia and hypothyroidism, but she also had a very large empyema of the right chest. This was surgically drained and treated with large doses of procaine penicillin G intravenously. Over time, her thyroid dysfunction, anemia, and empyema cleared. She still resides in a local nursing home and has done well except for the development of a large gastric ulcer. Her hypothyroidism has remained because she would take the medication from her nurse but discard it when the nurse left the room. This case has been a prime example of personal neglect, family neglect, and financial abuse. The patient's attitude and refusal to cooperate has been a contributing factor in her dilemma.

The second case we shall present was that of an incompetent 53-year-old paraplegic veteran whose caretaker was a nephew who operated a home care center for veterans in an eastern state. They stopped in our city en route to Florida after the boarding home had been closed by authorities. When neighbors here reported verbal and physical abuse, our GAIT was able to enter the patient into our hospital for evaluation, when our psychologist member detected signs of violence in the behavior of the nephew-caretaker. The psychologist was able to make an agreement with the caretaker to visit only when he was present. The caretaker had been cashing the veteran's check for his own personal use; this was a typical situation where physical, verbal, financial, and possible sexual abuse occurred together—although there was evidence of sexual abuse in this case, we were unable to obtain conclusive proof.

From the TMA Long Term Health Care Committee. Dr. Clark is with the Family Practice Center, Department of Family Practice, University of Tennessee Center for the Health Sciences, Jackson.

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During this period, the caretaker had also assaulted a food stamp employee (or representative).

The third case is that of an 81-year-old white woman who was very affluent. She had been cared for by her nephew, had round-the-clock sitters, and everyone was at her command. When w[illegible]is lady, she was taking, or had an[illegible]dications from 14 physicians. She had obviously been very demanding and the physicians would become frustrated, exhausted, and find some way to discharge her from their care. She had a large grocery sack of both prescription and over-the-counter medications. She made numerous phone calls to me, my secretary, and the nursing staff. It was our job to convince the patient and her caretaker that a nursing home, with a somewhat controlled environment, would be better for her. She was placed in a local nursing home where she had only one sitter, and the nursing home staf[illegible]ndered the needed care. By this time she had shown significant organic brain dysfunction, and not only did she receive better care, but her family was able to have needed rest.

At the time this lady needed a conservator I thought I had no problem; a psychiatrist who had treated both the patient and her nephew was called as a consultant. After the evaluation, however, the psychiatrist chose to disengage himself from the case, and though he was the one health care professional who could have resolved this case, he refused to render an opinion. This, in our experience, is not unusual, even though we try very hard to keep these physicians involved in decision-making. Our educational system has been lacking in that it apparently does not instill the value of their contribution and their professional comfort into the circumstances that at times may be very complex, trying and exhausting. No person can stand alone in the decisions that have to be made in order to serve the best interests of the clients.

The case histories presented here are but a few of the ones we have been able to resolve satisfactorily, though unfortunately we are not able to find solutions for all abuse cases.

I have tried to present geriatric abuse in all of its aspects—the numbers of occurrences, types of abuse, and typical cases. The GAIT with its multidisciplinary approach has been found to be workable. Our clients have almost always benefited, and have been grateful for our efforts, making this a satisfying professional experience for each team member.

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ELDER ABUSE TEAM IN A FAMILY PRACTICE SETTING – GAIT

By Curtis B. Clark, M.D.

The first recorded congressional hearing on domestic violence against the elderly was held by a Subcommittee on Human Services on the Select Committee on Aging, House of Representatives (96th Congress, 2nd Session, April 28, 1980). Ms. Geraldine A. Ferraro who had served in the District Attorney's office in Queens County, gave the opening remarks.

"At the same time, I urge to Congress, the social services providers and American families not to overlook this serious problem. Statistics indicate that domestic violence against senior citizens is occurring with alarming frequency, and it is increasing. I am concerned that the failure to improve services for these victims will only increase our nursing home population and increase the number of senior citizens who are physically and mentally damaged."

Approximately six years ago, after being presented cases of elder citizens whose condition was found to be based on some sort of abuse, we set out to organize an abuse team designed solely for the detection and resolution of persons over 60 years of age who were abused in some manner. The basic reasons were to improve service to our clients and offer an expanded perspective in the broad based training of our family practice residents.

Occurrences of abuse were not unusual, but they had been, at best, difficult and time consuming to manage. A search of the literature did not reveal the presence of a similar approach. There was very little documented medical literature or research available on this matter. To define the scope of the problem and to test different interventions, we developed a Geriatric Abuse Intervention Team (GAIT) in 1979.

COMPOSITION OF THE TEAM – As the physician member of the team, my responsibilities were to identify problems, evaluate situations medically and have input to the overall plan of management. Two nurse clinicians focused on the social, physical, and nursing needs that were necessary for the patient's care. A local representative from the Department of Human Services was a great source of strength in determining and meeting the economic, social, and legal aspects of the patient's problem. A psychologist with considerable experience in the psychodynamics of families and helping to evaluate and direct the psychological ramifications of the client's needs has been indispensable. A pharmacist had input concerning medications and pharmacology of the patients involved. An educational psychologist was involved to assist in the educational aspects of GAIT. Recognizing the educational potential of GAIT, social studies students, pharmacy students and family medicine residents in our program have participated.

The success of the team has depended on the expertise of all professionals represented, their caring for people and their willingness to forego their individuality for the sake of the patient and the resolution of the problem. Professional or personal jealousy has no place on such a team. Since health care professionals do change areas of work, the team has been one of evaluation; as residents complete the program, others join the team. Many of our patients have been followed for several years on a regular basis by the team.

Patients come from individual practice, the Department of Human Services or from referrals from clinicians in our communities. Every effort is made to maintain the involvement of the referring physician in the patient's care.

RESULTS AND DISCUSSION – Abuse of the elderly is probably more difficult to suspect than that of the child. We have been aware of child abuse much longer and studied it more intensively. Geriatric persons are more isolated and less visible, therefore, making their abuse more difficult to diagnose and less obvious to detect. The types of abuse seen include physical violence, emotional, financial and sexual abuse. In our experience, we have usually found more than one type of abuse effecting the same patient.

The greater the degree of disability, the greater the risk that a person may be abused. The data suggests that the typical person likely to be abused is a person 84 years of age, female, protestant, lower or middle class, and living with relatives. Current data suggests that 10% of persons over 60 years of age are being abused in some manner.

As a result of our experiences, the Department of Human Services

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GAIT – A RESIDENT'S PERSPECTIVE

By T. Randall Curtis, M.D.

"Youth is a blunder, manhood a struggle, old age a regret"
-Disraeli

Growing up in a small rural community I was taught to respect the "old people". I had never heard of, let alone witnessed, anyone harming a geriatric person. As a teenager, I visited my brother in a large city where I witnessed, close up, two young teenage girls strike a fragile elderly woman and snatch her purse. The woman fell to the sidewalk and was bleeding profusely from a head injury. Looking back into my medical career, pre-med, and medical school, this was mainly what I thought of as "geriatric abuse".

More recently I have been involved in cases of a more subtle nature, but just as harmful as the incident I had observed as a teenager. These cases involved personal neglect, family denial/neglect, physical, psychological, sexual, and financial abuse. As I investigated and became more aware of the nauseating details of some of the injustices done to these defenseless human beings, I was appalled; I felt anger, disgust, depression, and most of all, helplessness.

In talking with other residents, both in family practice and internal medicine, and some physicians who have been practicing for many years, I realized they had experienced similar situations, but very few realized that the number of cases was so great. After talking with friends outside the medical field, I realize that most people think that geriatric abuse is extremely rare, especially in comparison to child abuse, when in fact it occurs about as often.

Upon realizing my limited knowledge, along with many other physicians in this aspect of geriatrics, I sought help. I was extremely fortunate to be in a family practice residency program that had a family practitioner on its faculty who was very concerned about total patient care with a special interest in geriatric patients. He informed me of the local Geriatric Abuse Intervention Team (GAIT) which he helped organize. I rapidly appreciated the expertise and results of this interdisciplinary team. Decisions are not just made, implemented, and forgotten, but ongoing follow-up takes place.

One case quickly comes to mind. This was an elderly, malnourished, white male who was admitted with a diagnosis of cerebral and cerebellar atrophy causing a severe problem with ataxia and seizure. He also abused ETOH. Upon investigating his home, it was discovered that he lived alone in an unkempt home with a "pile" of walking canes in one corner as if he had been looking for a magic cane to allow him to remain agile and independent. Neighbors stated that he was unable to cook, and they carried food to him occasionally. It was uniformly decided that Mr. X could not survive in this home situation. He adamantly refused nursing home placement and family members originally refused guardianship or to take him into their homes.

With the help of the Department of Human Services and GAIT the patient's nephew, who was an alcoholic, agreed to accept guardianship, and the patient was discharged to the nephew's home with plans for close outpatient follow-up. Mr. X's niece agreed that her uncle was not receiving adequate care at the nephew's house. She agreed to take him into her home and care for him. The patient has been doing quite well in this situation. With the help of the Department of Human Services and GAIT, this was possible. Unfortunately, this is not the end of the story. On his last visit to the clinic, I learned that Mr. X's niece has terminal lung cancer and will be unable to care for Mr. X. I am unsure what care will be implemented, but with GAIT's help, I feel that the solution will be much less difficult and time consuming than one I could make alone.

As a family practitioner, I plan to practice total family care. Therefore, I will be in an ideal situation to detect geriatric abuse in early stages. I now feel more comfortable in recognizing subtle signs of geriatric abuse, yet I feel that the complicated, time-consuming task of resolving these cases with the patient's best interest in mind will be best managed by an interdisciplinary team of professionals such as GAIT.

The Geriatric Abuse Intervention Team has successfully fulfilled its goals as advocate for many vulnerable geriatric persons in our area. More similar teams are

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of the State of Tennessee had two trial teams formed using our approach to this problem. After one year's trial it was determined that such a team would be developed in each of the eight areas of the state. These teams now function under the supervision of the Adult Protective Services of the State of Tennessee.

We are not able to resolve all of the cases that come to our attention, however, we have been able to resolve a high percent satisfactorily, or at least lessen the severity of abuse. We have had problems in reaching solutions in which there is family conflict. Family conflicts make evaluation of geriatric abuse a very complex situation, and the real truth may be extremely difficult to ascertain. Many times those being abused are not able to verbally communicate or do not have the mental capacity to do so in a competent manner. Cases of abuse have been alleged at times by disgruntled friends or family in an effort to bring embarrassment, but after investigation, these charges were found to be false.

When authorities would start to become suspicious of abuse, the daughter would move the patient to another city, each time contacting all the available social support agencies such as churches, Salvation Army, or welfare services. Diagnostic hospital work-up did not show significant problems from those previously suspected. After full consultation with GAIT, the decision was made to enter the court system to allow custody to be given to the department of Human Services. Such action is taken only when no other suitable guardian can be found. The court did grant custody to the Department of Human Services. Resolution of this case was accomplished in 72 to 96 hours.

Dr. Clark is an Assistant Professor of Family Medicine, University of Tennessee.

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needed. Communities can organize teams utilizing those available individuals who are interested in working together to resolve such dilemmas. GAIT works!

Dr. Curtis is a Resident in Family Medicine, PGY II, University of Tennessee.

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